PATIENT MEDICAL HISTORY

Name _____ Date of Birth _____ Age _____
Occupation _____ Full-time/part-time/retired

In general, would you say your overall health right now is…?
a. Excellent b. Very Good c. Good d. Fair e. Poor
Do you now, or have you ever had, problems with the following…

	Yes	No		Yes	No		Yes	No
Falls			Allergy to Cold			Pins & Needles		
Diabetes			Other Allergies			Bowel/ Bladder Changes		
High Blood Pressure			Night Sweats			Unexplained Night Pain		
Pacemaker			Previous Surgery			Circulatory Problems		
Chronic Headaches			Seizures			Persistent Fevers		
Kidney Problems			Metal Implants			Sleep Issues		
Nervous Disorders			Dizziness			Fractures		
Hernia			Cancer			Recent Weight Loss		
Allergy to Heat			Pregnant			Problems with both Arms & Legs at the Same Time		
Bone Disease			Osteoporosis					

If YES to any of the above, please explain and give details: _____
_____
_____
_____

Are you presently taking any medications? YES ____NO___
If YES, please list your medications and for what condition: _____
_____

Is there anything else we should know about your general health, or current condition? Please explain and, if necessary, we can talk about it: _____
_____

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