Medical History

ARE YOU/IS THERE ANY CHANCE YOUR PREGNANT? YES NO

PLEASE DESCRIBE ANY OF THE FOLLOWING THAT YOU HAVE HAD IN THE PAST. INCLUDE DATES IF POSSIBLE.

ALLERGIES (SEASONAL/MEDICATION) _____
DISLOCATIONS/FRACTURES _____
HEAD INJURIES _____
SURGERIES/HOSPITILIZATIONS _____
OTHER INJURIES _____

LIST ANY MEDICATIONS/VITAMINS/MINERALS/SUPPLEMENTS YOU ARE TAKING OR HAVE RECENTLY TAKEN.

_____
_____
_____

HABITS

DO YOU SMOKE? _____ IF YES, HOW MANY PACKS PER DAY? _____
DO YOU DRINK? _____ IF YES, HOW MANY DRINKS PER WEEK? _____
HIGH STRESS LEVEL? _____ IF YES, WHAT IS REASON? _____

WORK ACTIVITY

SITTING _____ LIGHT LABOR _____
STANDING _____ HEAVY LABOR _____

DATE OF LAST: PHYSICAL EXAM _____ SPINAL XRAY _____ BLOOD TEST _____
SPINAL EXAM _____ CHEST XRAY _____ URINE TEST _____
MRI, CT, BONE SCAN _____

PLEASE CIRCLE "Y" FOR ANY CONDITION YOU HAVE EXPERIENCED IN THE PAST OR ARE EXPERIENCING AT THIS TIME. CIRCLE "N" FOR A CONDITION YOU HAVE NOT EXPERIENCED IN THE PAST OR AT THIS TIME.

AIDS/HIV	Y / N	HEPITITIS	Y / N	SCARLET FEVER	Y / N
ALCOHOLISM	Y / N	HERNIATED DISC	Y / N	STROKE	Y / N
ALLERGY SHOTS	Y / N	HERNIA	Y / N	SUICIDE ATTEMPT	Y / N
ANEMIA	Y / N	HERPES	Y / N	THYROID PROBLEMS	Y / N
ANOREXIA	Y / N	HIGH BLOOD PRESSURE	Y / N	TONSILLITIS	Y / N
APPENDICITIS	Y / N	HIGH COLESTOREROL	Y / N	TUBERCULOSIS	Y / N
ARTHRITIS	Y / N	KIDNEY DISEASE	Y / N	TUMORS/GROWTHS	Y / N
ASTHMA	Y / N	KIDNEY INFECTION	Y / N	TYPHOID FEVER	Y / N
BLEEDING DISORDER	Y / N	LIVER DISEASE	Y / N	ULCERS	Y / N
BREAST LUMP	Y / N	MEASLES	Y / N	VAGINAL INFECTIONS	Y / N
BRONCHITIS	Y / N	MIGRAINES	Y / N	VUNEREAL DISEASE	Y / N
BULIMIA	Y / N	MISCARRIAGE	Y / N	WHOOPING COUGH	Y / N
CANCER	Y / N	MONONUCLEOSIS	Y / N		
CARPUL TUNNEL	Y / N	MULTIPLE SCLEROSIS	Y / N		
CATARACTS	Y / N	MUMPS	Y / N	NECK PAIN	Y / N
CHEMICAL DEPENDENT	Y / N	OSTEOPOROSIS	Y / N	BACK PAIN	Y / N
CHICKEN POX	Y / N	PACEMAKER	Y / N	MUSCLE STRAIN	Y / N
DIABETES	Y / N	PARKINSON'S DISEASE	Y / N	LIGAMENT SPRAINS	Y / N
EMPHYSEMA	Y / N	PINCHED NERVE	Y / N	BURSITIS	Y / N
EPILEPSEY	Y / N	PNEUMONIA	Y / N	PLANTAR FASCITIS	Y / N
FRACTURES	Y / N	POLIO	Y / N	HEADACHES	Y / N
GLAUCOMA	Y / N	PROSTATE PROBLEM	Y / N	SHOULDER PAIN	Y / N
GOITER	Y / N	PROSTHESIS	Y / N	SCIATICA	Y / N
GONORRHEA	Y / N	PSYCHIATRIC CARE	Y / N	SCOLIOSIS	Y / N
GOUT	Y / N	RHEUMATOID ARTHRITIS	Y / N	SWOLLEN JOINTS	Y / N
HEART DISEASE	Y / N	RHEUMATIC FEVER	Y / N	OTHER _____	

FAMILY HISTORY

____ CANCER	____ HIGH BP	____ LIVER DZ	____ OTHER
____ STROKE	____ HIGH COLESTEROL	____ PROSTATE DZ	_____
____ DIABETES	____ KIDNEY DZ	____ METABOLIC DZ	

I ACHNOWLEDGE THAT ALL INFORMATION LISTED ABOVE CONCERNING MY PERSONAL HEALTH HISTORY IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ DATE: _____