Medical History

Patient's Name ____ Height ____________

Reason for Visit _______________________________________ Weight ____________

Date when symptoms/accident occurred: ____________________ Ref Dr ____________

Is the symptoms/accident related to (circle) AUTO SPORTS WORK OTHER _____________

What symptoms are you experiencing now: ____

Do you have other medical problems?

____

____

Have you had any surgery (Head to Toe)? Please list

____

____

Please list all medications and dosage(s)

____

____

____

Do you have any medication allergies?

____

____

Do you (circle) Drink Alcohol Smoke Tobacco How much? __________________________

Do you experience abnormal bleeding with surgery, cuts, extractions or trauma? Yes or No

Are you, or is there a chance, you are pregnant? Yes or No

Circle if any blood relatives have had any of the following:

- Arthritis
- Cancer (type _________)
- Diabetes
- Gout
- Heart Disease
- Hypertension
- Kidney Disease
- Stroke
- TB