# MEDICAL HISTORY

Name_____ Date_____

ALL >YES= ANSWERS REQUIRE EXPLANATION ON OTHER SIDE

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ____ | ____ | Allergies | ____ | ____ | Hay Fever |
| ____ | ____ | Asthma | ____ | ____ | Emphysema |
| ____ | ____ | Diabetes | ____ | ____ | Tuberculosis |
| ____ | ____ | Heart Problems | ____ | ____ | High Blood Pressure |
| ____ | ____ | Low Blood Pressure | ____ | ____ | Pacemaker |
| ____ | ____ | Rheumatic Fever | ____ | ____ | Fainting/Dizzy Spells |
| ____ | ____ | Tumor/Cancer | ____ | ____ | Jaundice or Hepatitis |
| ____ | ____ | Previous Head Injury | | | |

| | | |
|---|---|---|
| ____ | ____ | Do you suspect you may be pregnant? |
| ____ | ____ | Chronic or recurrent illness? |
| ____ | ____ | Illness lasting more than one week? |
| ____ | ____ | Hospitalizations? |
| ____ | ____ | Surgery other than tonsillectomy? |
| ____ | ____ | Injuries requiring treatment by a physician? |
| ____ | ____ | Allergies to any medications (aspirin, penicillin, etc.)? |
| ____ | ____ | Other joint sprains or dislocations (shoulder, wrist, ect.)? |
| ____ | ____ | Do you have any metal screws/plates? |

What is your MAIN problem?_____

Do you have any secondary problems?_____

HOW and WHEN did your problem begin?_____

Have you ever had anything similar before? _____ Explain

_____

Are you currently working? _____ If not, is it because of your problem?

_____

Do you feel there is any other medical information which may be helpful in the event of a medical emergency or which will effect your treatment?

_____

_____

In case of medical emergency, please notify: Name_____

Phone_____