

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

