PAST MEDICAL HISTORY FORM

Please fill out the entire form

Patients Name:_____ Date:_____

Date of Injury/ onset:_____ Have you ever had this injury before? Yes No

Cause of Injury:_____ Have you had a related surgery? Yes No

Do you have or have you had any of the following?

Allergies	Yes	No	**Dizzy Spells**	Yes	No	**MRSA**	Yes	No
Anemia	Yes	No	**Emphysema/ Bronchitis**	Yes	No	**Multiple Sclerosis**	Yes	No
Anxiety	Yes	No	**Fibromyalgia**	Yes	No	**Muscular Disease**	Yes	No
Arthritis	Yes	No	**Fractures**	Yes	No	**Osteoporosis**	Yes	No
Asthma	Yes	No	**Gallbladder Problems**	Yes	No	**Parkinson's**	Yes	No
Autoimmune Disorder	Yes	No	**Headaches**	Yes	No	**Rheumatoid Arthritis**	Yes	No
Cancer	Yes	No	**Hearing Impairment**	Yes	No	**Seizures**	Yes	No
Cardiac Conditions	Yes	No	**Hepatitis**	Yes	No	**Smoking**	Yes	No
Cardiac Pacemaker	Yes	No	**High Cholesterol**	Yes	No	**Speech Problems**	Yes	No
Chemical Dependency	Yes	No	**High/Low Blood Pressure**	Yes	No	**Strokes**	Yes	No
Circulation Problems	Yes	No	**HIV/ AIDS**	Yes	No	**Thyroid Disease**	Yes	No
Currently Pregnant	Yes	No	**Incontinence**	Yes	No	**Tuberculosis**	Yes	No
Depression	Yes	No	**Kidney Problems**	Yes	No	**Vision Problems**	Yes	No
Diabetes	Yes	No	**Metal Implants**	Yes	No			

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

_____

_____

PAST SURGERIES

Body Region	Surgery	Date	Body Region	Surgery	Date
_____	_____	____, ____, ____	_____	_____	____, ____, ____
_____	_____	____, ____, ____	_____	_____	____, ____, ____
_____	_____	____, ____, ____	_____	_____	____, ____, ____
_____	_____	____, ____, ____	_____	_____	____, ____, ____

FALL HISTORY

Have you had an injury as a result of a fall in the past year? Yes No

Two or more falls in the past year? Yes No

MEDICATIONS

Are you presently taking medications? Yes No **If yes, please fill out below*

Drug	**Dosage**	**Frequency**	**Route**	**Reason Taking**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____