

Medical History Form



Patient Name: _____

Date: _____

Information about current problem:

1. Is this injury related to? Work Car Accident Other Liability/potential Lawsuit Not Applicable
2. Do you have Primary Care Physician/Family Doctor Yes NO
If YES, please provide a date of last appointment _____
3. Race/Ethnicity (please select one)
 (Caucasian) White Hispanic Not Hispanic Asian
 African American Native American Other

If you are a Medicare beneficiary, you are required by Medicare to answer the following questions:

4. Do you consume more than 7 alcoholic drinks in a week YES NO

Mark One Box for each item	NO	YES Under a year	YES, Over a year	mark one box for each item	NO	YES, under a year	YES Over a year
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder/bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circulation/vascular problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Cloth/DVT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever/nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Groin Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Difficulties/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain/fibro/headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metal implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychological condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Faintness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringling in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats/night pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Condition	NO	YES	If YES, please specify
Infection disease			
Neurologic condition (MS/Parkinson's)			
Skin Disease			
Spinal Cord Injury			
Degenerative Joint Disease			