PATIENT HISTORY Today's Date_____
Name:_____ Date of Birth_____

What is your problem to evaluate today?_____
Was this an injury? No___Yes___ Date your problem occurred _____
If an injury, give details of how it occurred_____

Have you had treatment for this? No___Yes___ When?_____
Give details of treatment:_____

Have you had x-rays or MRI taken? No___Yes___ Where?_____

What is your occupation?_____

List any medications you are now taking for this problem (including non-prescription)_____

Pharmacy phone number:_____

Medicines: List all medicines you are now taking or attach your list. Include non-prescription and over-the-counter medications.

_____ _____ _____
_____ _____ _____

Check any of these medicines/things that you are allergic to:
___Aspirin ___Antibiotics ___Penicillin ___Sulfa ___Betadine ___Codeine
___NSAIDS ___Ultram/Tramodol
Are you allergic to anything else?_____

Family Medical History: *Please indicate if anyone in your family has any of the following* (M=Mother; F=Father; B-Brother; S=Sister)
Bleeding Disorders___ Cancer ___ Diabetes___ Heart Disease___
Hypertension___ Rheumatoid Arthritis___ Gout___ Other?_____

PLEASE FILL OUT THE BACK OF THIS PAGE

Previous Surgeries or Injuries:

Year	Operation/Illness	Name of Hospital	City & State

Have you ever had:

MI/Heart attack	Yes___No___	Height:___Ft___Inches	
Chest Pains/Angina	Yes___No___	Weight:_____lbs	
Heart Murmur	Yes___No___	Alcohol Usage	Yes___No___
Blood Clots	Yes___No___	Drug Usage	Yes___No___
Skipped Heart Beats/A-Fib	Yes___No___	Do You Smoke	Yes___No___
High Blood Pressure	Yes___No___	Diabetes	Yes___No___
Stoke	Yes___No___	Hepatitis	Yes___No___
Epilepsy/Convulsions	Yes___No___	Thyroid Disorders	Yes___No___
Asthma	Yes___No___	Kidney Disorders	Yes___No___
Bronchitis	Yes___No___	Sickle Cell	Yes___No___
Emphysema	Yes___No___	Bleeding Tendency	Yes___No___
Shortness of Breath	Yes___No___	Hiatal Hernia	Yes___No___
Pneumonia	Yes___No___	Ulcers	Yes___No___
Sleep Apnea	Yes___No___	Glaucoma	Yes___No___
Reflux or Gerd	Yes___No___	History of DVT	Yes___No___
Adverse anesthesia problems	Yes___No___	HIV/AIDS	Yes___No___