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PATIENT HISTORY **Date _____**

Name: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

Occupation/Job Duties: _____

Sports/Exercise activities you are involved in: _____

Body area(s) to be examined: _____

Date of onset of symptoms or injury: _____ Referring Physician: _____

If an injury/accident, how and where did it occur? _____

_____

Briefly describe your symptoms: _____

_____

Have you had any x-rays taken for this problem? _____ Where? _____

Date Taken: _____ Area of body x-rayed: _____

Is there any litigation pending on this injury? _____ Attorney's name/phone: _____

lease review the following list and check "yes" if you presently have or have ever had any of the problems, "no" if not:

	YES	NO		YES	NO		YES	NO
Asthma	☐	☐	Bleeding Problems	☐	☐	Stroke	☐	☐
Bronchitis	☐	☐	Sickle Cell Illness	☐	☐	Seizures	☐	☐
Hay Fever	☐	☐	Stomach Ulcers	☐	☐	Polio/Paralysis	☐	☐
Tuberculosis	☐	☐	Jaundice/Hepatitis	☐	☐	Cancer	☐	☐
Chronic Cough	☐	☐	Liver Problems	☐	☐	Tumors	☐	☐
Shortness of Breath	☐	☐	Gallstones	☐	☐	Arthritis	☐	☐
Rheumatic Fever	☐	☐	Colitis/Diverticulitis	☐	☐	Rheumatoid Arthritis	☐	☐
Heart Attack	☐	☐	Kidney Stones/Disorders	☐	☐	Blood Transfusions	☐	☐
Heart Murmur	☐	☐	Bladder Infection	☐	☐	Exposure to AIDS	☐	☐
High Blood Pressure	☐	☐	Diabetes	☐	☐	Other:_____		

List prior surgeries and approximate dates:

_____

_____

_____

_____

List current medications and dosage:

_____

_____

_____

_____

Do you smoke? _____ Packs per day? _____

Do you drink alcohol? _____ Drinks per day? _____

Are you pregnant? _____ Due Date: _____

Are you allergic to any medications? _____

If yes, please list: _____

_____

Are you right or left hand dominant? _____

Name of Preferred Pharmacy: _____

Name of Primary Care Physician: _____

Primary Physician's phone number: (_____)_____