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	☐	☐	☐	Sexual dysfunction	☐	☐	☐
High Blood Pressure	☐	☐	☐	Bladder/bowel problems	☐	☐	☐
Circulation/vascular problems	☐	☐	☐	Seizures	☐	☐	☐
Blood Clot/DVT	☐	☐	☐	Head injury	☐	☐	☐
Stroke	☐	☐	☐	Obesity	☐	☐	☐
Chest Pain	☐	☐	☐	Fever/nausea	☐	☐	☐
Kidney Condition	☐	☐	☐	Groin Numbness	☐	☐	☐
Diabetes	☐	☐	☐	Osteoporosis	☐	☐	☐
Smoking	☐	☐	☐	Arthritis	☐	☐	☐
Breathing Difficulties/Asthma	☐	☐	☐	Fractures	☐	☐	☐
Cancer	☐	☐	☐	Infection	☐	☐	☐
Difficulty swallowing	☐	☐	☐	Chronic pain/fibro/headaches	☐	☐	☐
Metal implants	☐	☐	☐	Psychological condition	☐	☐	☐
Pacemaker	☐	☐	☐	Dizziness/Faintness	☐	☐	☐
Peripheral Neuropathy	☐	☐	☐	Ringing in ears	☐	☐	☐
Unexplained weight loss	☐	☐	☐	Allergy to latex	☐	☐	☐
Double vision	☐	☐	☐	Other allergy	☐	☐	☐
Night sweats/night pain	☐	☐	☐	Are you pregnant?	☐	☐	☐

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