PAST MEDICAL HISTORY

Name:____ Age:_________________

Please state your diagnosis as told to you by your physician: ____

HAVE YOU EVER HAD THE FOLLOWING CONDITIONS? (Please check)

	YES	NO		YES	NO
Heart Trouble	___	___	**Asthma**	___	___
High Blood Pressure	___	___	**Emphysema**	___	___
Diabetes	___	___	**Back Injury**	___	___
Headaches	___	___	**Arthritis**	___	___
Dizzy Spells	___	___	**Bleeding Disorder**	___	___
Fainting Spells	___	___	**Fracture**	___	___
Epilepsy	___	___	**Cancer**	___	___
Stroke	___	___	**Pacemaker**	___	___
HIV	___	___	**Tuberculosis**	___	___
Hepatitis	___	___	**Osteoarthritis**	___	___

Have you been out of the country in the last 6 months: Yes___ No___ If yes, where? _____________

REGARDING YOUR PRESENT INJURY/CONDITION:

Date of Injury/Condition: ____

How did the injury occur? ____

Have you been hospitalized for the present problem? Yes: ___ No:___

Have you had surgery for the present problem? Yes:___ (date):______, No:___

Are you currently receiving Physical Therapy or Home Health Treatment? Yes: ___ No: ___

If so, please summarize the results: ____

Last seen by physician for present problem? ____________Next M.D. appt. date:________

At the present time would you say your health is: Excellent: _____ Very Good: ____ Fair: _____ Poor: ____

Are you being seen by any other physician? ____

Are you on medication: Yes: ___ No: ___ If so, please state type(s) of medication:

____

Which of the following best describes your symptoms? (Please check where appropriate)

Sharp ___ Dull ___ Burning ___ Numbness ___ Constant ___ Intermittent ___ Pins and Needles ___

Other ____

Using a scale of 1 -10, please rate your pain. (1 being the lowest, 10 being the most pain): ____________________

Signature of person completing form: ____Date:________