MEDICAL HISTORY
Page #1

PATIENT REGISTRATION

Name: _____Date:_____

MEDICAL HISTORY

Height: _____ Weight:_____ Age: _____

Allergies ?

Medicines? Y N Which?_____
Environment? Y N Which?_____
Foods? Y N Which?_____
Metals (i.e.: titanium, surgical steel)

Skin

Rashes, Skin Cancers, Scarring, etc
Y N
Explain:_____

General

Cancer?	Y	N	Recent Chemo/Radiation?	Y	N
Fevers?	Y	N	Chills?	Y	N
Unexplained Weight Loss?	Y	N	Anemia?	Y	N
Unexplained weight gain?	Y	N	Pain?	Y	N
Do you exercise?	Y	N	Easy bruising?	Y	N
Blood Clotting problem?	Y	N	Swollen Glands?	Y	N
Do you eat well?	Y	N	Do you diet?	Y	N

Explain:_____

Eyes

Blurred vision?	Y	N	Pain?	Y	N
Double vision?	Y	N	Dry eyes?	Y	N
Corrective glasses?	Y	N	Contact lenses?	Y	N

Explain:_____

Ear/Nose/Throat/Mouth

Sinus problems?	Y	N	Breathing problems?	Y	N
Snoring?	Y	N	Other?	Y	N

Explain_____

MEDICAL HISTORY
Page #2

Name: _____Date:_____

Endocrine

Diabetes?	Y	N	Thyroid?	Y	N

Explain_____

Gastrointestinal

Abdominal pain?	Y	N	Gallstones?	Y	N
Black/Bloody Stools?	Y	N	Heartburn/reflux	Y	N
Liver disease?	Y	N	Hepatitis?	Y	N

Explain_____

Cardiovascular

Heart Disease(blocked arteries)	Y	N	Blood vessel Disease	Y	N
Chest pain?	Y	N	Heart murmur?	Y	N
High blood pressure?	Y	N	High cholesterol?	Y	N
Heart valve problem?	Y	N	Heart attack?	Y	N

Explain_____

OB/GYN

Pregnancies?	Y	N	if so, #_____
Are you currently pregnant?	Y	N	
Mammogram?	Y	N	if so, when _____
Breast surgery?	Y	N	if so, for _____

Respiratory

Wheezing?	Y	N	Chronic cough?	Y	N
Shortness of breath?	Y	N	Asthma?	Y	N
Emphysema?	Y	N	Lung Cancer?	Y	N
Lung Cancer?	Y	N			

Explain_____

Social History

Alcohol use?	Y	N	How much?_____
Tobacco use?	Y	N	How much?_____
Drug use?	Y	N	Which ones?_____
AIDS/HIV Exposure?	Y	N	

Explain_____

MEDICAL HISTORY
Page #3

Name: _____Date:_____

Neurological

Headaches?	Y	N	Dizzy spells?	Y	N
Stroke?	Y	N	Numbness/tingling?	Y	N
Seizures?	Y	N	Spine problems?	Y	N
			***see complaint and pain drawing**		

Explain_____

Psychiatric

Anxiety?	Y	N	Other? (explain)	Y	N
Depression?	Y	N			

Explain_____

Surgical History:
Please list all operation and approximate dates- include any previous spine or brain surgery.

_____
_____
_____
_____

Medications:
Please list all medications and dosages. Be sure to list any vitamins and herbal remedies as well.

_____
_____
_____
_____
_____
_____
_____

Patient Signature:_____
Date:_____

Patients who come in for follow up visits must check their health history form. If there have been no changes since your last visit please date and sign this form.

If however changes have occurred in your health history please let the office know and we will give you an additional form to complete.

Thank You for your cooperation.