MEDICAL HISTORY

Name: _____ Date: _____

Present Illness or Injury

For what condition or symptoms are we seeing you? _____

When did it begin (date and explain) _____

What treatment have you already received? _____

Past Medical History *(please indicate if you have had any of the following conditions in the past or have currently)*

Heart Disease/ Heart Attack	Yes	No
Arthritis	Yes	No
Epilepsy or Convulsions	Yes	No
Diabetes	Yes	No
Emphysema	Yes	No
Tuberculosis	Yes	No
Ulcers	Yes	No
Hernia	Yes	No
Venereal Disease	Yes	No
Thyroid Disease	Yes	No
Osteoporosis	Yes	No
Migraine Headaches	Yes	No
Fainting	Yes	No
Back Pain	Yes	No
Hemorrhoids	Yes	No
Do you have surgical implants?	Yes	No
High Blood Pressure	Yes	No
Stroke	Yes	No
Kidney/ Bladder Problems	Yes	No
Tumor or Cancer	Yes	No
Asthma/Chromic Bronchitis	Yes	No
Hepatitis	Yes	No
Blood Disorders	Yes	No
Congenital Abnormalities	Yes	No
Genital/ Gynecological Disorder	Yes	No
Alcoholism / Drug Abuse	Yes	No
Pacemaker	Yes	No
Allergies	Yes	No
Mental Disorder	Yes	No
Sinus Problems	Yes	No
Are you pregnant?	Yes	No

Other medical problems not listed (explain) _____

_____

_____

_____

Surgeries (list all previous surgeries and dates performed)

_____

_____

_____

List Medications: Freq/Dosage

_____

_____

_____

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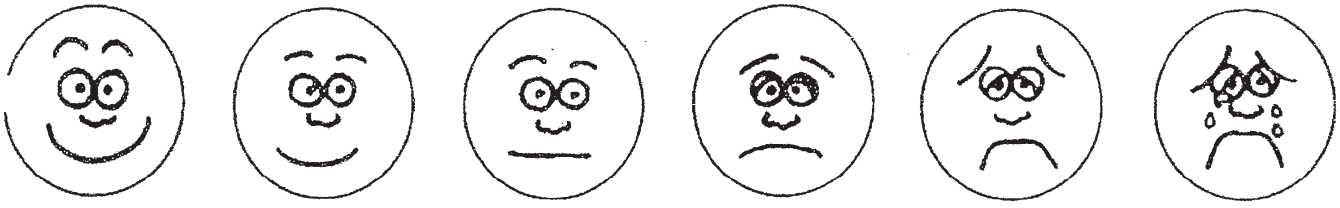
_____

PAIN SCALE: Please choose which picture/numbers describe your pain at the present time:

0/10 _____ **2/10** _____ **4/10** _____ **6/10** _____ **8/10** _____ **10/10** _____



NO HURT | **HURTS LITTLE BIT** | **HURTS LITTLE MORE** | **HURTS EVEN WORSE** | **HURTS WHOLE LOT** | **HURTS WORSE**