PATIENT MEDICAL HISTORY

NAME: ____________________________ DATE OF BIRTH: ________________________

HAVE YOU HAD ANY OF THE FOLLOWING?

AIDS/HIV	Diabetes	Liver Disease	Rheumatoid
Alcoholism	Emphysema	Measles	Arthritis
Allergies	Epilepsy	Migraines	Rheumatic Fever
Anemia	Fractures	Miscarriage	Scarlet Fever
Anorexia	Glaucoma	Mononucleosis	Sexually Transmitted Disease
Appendicitis	Goiter	Multiple Sclerosis	Stroke
Arthritis	Gonorrhea	Mumps	Thyroid Problems
Asthma	Gout	Osteoporosis	Tonsilitis
Bleeding Disorder	Heart Disease	Pacemaker	Tuberculosis
Breast Lump	Hepatitis	Parkinson's Disease	Tumors/Growths
Bronchitis	Hernia	Pinched Nerve	Typhoid Fever
Bulimia	Herniated Disk	Pnemonia	Ulcers
Cancer	Herpes	Polio	Vaginal Infections
Cataracts	High Blood Pressure	Prostate Problems	Whooping Cough
Chemical Dependency	High Cholesterol	Prosthesis	Other: _______________
Chicken Pox	Kidney Disease	Psychiatric Care	______________________

PLEASE EXPLAIN: ____

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EXERCISE: None Moderate Daily Heavy

HABITS: Smoking (Quantity): ________________ Alcohol (Quantity): ___________________

Coffee/Caffeine (Quantity): _________

PREVIOUS INJURIES/SURGERIES: ____

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MEDICATIONS: ____

ALLERGIES: ____

OTHER: ____

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