



PAST MEDICAL HISTORY INFORMATION

INDICATE IF YOU CURRENTLY OR IN THE PAST HAVE HAD ANY OF THE FOLLOWING:

DIABETES	_____	ALLERGIES	_____	URGE INCONTINENCE	_____
CANCER	_____	HEADACHES	_____	STRESS INCONTINENCE	_____
HEART DISEASE	_____	SEIZURES	_____	DIZZINESS, VERTIGO	_____
HEART ATTACK	_____	NUMBNESS	_____	DERMATITIS	_____
PACEMAKER	_____	ARTHRITIS	_____	HERNIA	_____
HIGH BLOOD PRESSURE	_____	FIBROMYALGIA	_____	IMPLANTS	_____
BLOOD DISORDERS	_____	OSTEOPOROSIS	_____	NERVOUS DISORDERS	_____
KIDNEY PROBLEMS	_____	OSTEOPENIA	_____	MENTAL OR OTHER DISORDERS	_____

DO YOU SMOKE? Yes _____ No _____ (Female patients only) ARE YOU PREGNANT? Yes _____ No _____

RECENT SURGERY? Yes _____ No _____ If yes, explain _____

LIST ANY DRUG OR FOOD ALLERGIES : _____

LIST MEDICATION YOU ARE PRESENTLY TAKING AND FREQUENCY:

ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW ABOUT YOUR MEDICAL HISTORY THAT WOULD HELP US BETTER TREAT YOUR PRESENT INJURY/COMPLAINT:

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE,

SIGNED:

DATE: