

Is there anything that helps your condition? (Example: Ice, rest, lying down, heat, medication...)

What makes your condition worse: _____

PAST MEDICAL HISTORY:

Please explain any and all medical conditions that you current suffer or have suffered from in the past.
(example: Heart disease, Diabetes, Cancer...)

1. _____
2. _____
3. _____
4. _____
5. _____

PAST SURGICAL HISTORY:

List any surgeries below:

1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES:

List any known allergies below:

1. _____
2. _____
3. _____

4. _____
5. _____

FAMILY HISTORY:

List any relevant family history below:

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS:

List any and all medications you are currently taking below:

1. _____
2. _____
3. _____
4. _____
5. _____

SOCIAL HISTORY:

Are you: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

Do you have any children? YES NO If yes, how many? _____

Are you pregnant? YES NO If YES, what month? _____

Do you use: TOBACCO ALCOHOL COFFEE - (Occasionally or Frequently?)

If yes for tobacco, are you: CURRENTLY USING QUIT

If currently using, what year did you start? _____ Quit: _____

You may return this form to the front desk. Thank you for taking the time to fill it out thoroughly.