

MEDICAL HISTORY FORM

Today's Date: _____

Name: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____ Handedness? R L Pregnant? Y N

Reason for today's visit: _____ Side Involved: R L

How did symptoms first occur? _____

How long have symptoms been present? _____

On a scale from 1 – 10 (with 10 being the worst), circle the number that best describes the pain/symptoms:

1 2 3 4 5 6 7 8 9 10

If injury: Date: _____ Place: _____

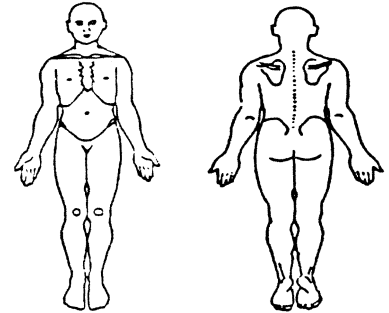
Work Related: Y N

Have you been treated elsewhere: Where? _____

By Whom? _____

X-rays/MRIs/Scans taken? Y N Where? _____

Please indicate where symptoms are present:



Medication allergies? _____

Anti-inflammatory use (list all taken): _____

List all medications you are taking and dosages: _____

List all previous surgeries: _____

Have you ever broken a bone from a simple fall or without trauma? Y N

If you are female > 65 or male > 70, was your previous bone density test more than 3 years ago? Y N No previous testing

Who is your Primary Care Physician: _____ Phone #: _____

Personal Habits:	Y	N	Amount		Y	N	Amount
Drink Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Exercise Regularly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Smoke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Wear Seat Belt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chew Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____				

I hereby certify that to the best of my knowledge any accident/injury information stated above is correct.

Patient Signature: _____ **Date:** _____