MEDICAL HISTORY

Healthcare regulations require medical providers to obtain and maintain a medical history file on each patient they provide care to. Your medical history is Protected Health Information (PHI) subject to Federal Regulations. All information provided here shall be maintained in your file according to the terms of our privacy and security policies, a copy of which had been made available to you. Thank you for your cooperation.

Name of patient:_____

Please describe the main reason for your visit:_____

Which side is affected? ☐ Right ☐Left ☐ Both Are you right handed or left handed? ☐Right ☐ left

Did your problem occur as a result of an accident or injury? ☐ Yes ☐ No If yes, please describe accident or injury:_____

Date of Injury_____ Did your injury occur while at work? ☐ Yes ☐ No

What is your occupation?_____

* Drug Allergies_____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL PROBLEMS:

	YES	NO	DETAILS
HIGH BLOOD PRESSURE			
DIABETES			
CANCER			
ARTHRITIS			
HEART DISEASE			
LUNG DISEASE			
ASTHMA			
DO YOU HAVE CHEST PAIN			
DO YOU HAVE PALPITATIONS			
HAVE YOU HAD A STROKE			
DO YOU HAVE SEIZURES			
DO YOU HAVE A PACEMAKER			
DO YOU HAVE METAL IN YOUR BODY OR JOINTS			
ARE YOU PREGNANT (WOMEN)			

PLEASE CONTINUE ON THE OTHER SIDE

NAME_____ DATE_____

PLEASE LIST ALL MEDICATIONS YOU CURRENTLY TAKE

MEDICATION	DOSE	HOW OFTEN

HAVE YOU HAD SURGERY OR BEEN HOSPITALIZED? IF YES, PLEASE DESCRIBE BELOW

DATE	LOCATION	REASON/ PROCEDURE

PLEASE DESCRIBE ANY MEDICAL PROBLEMS OR OTHER INFORMATION YOU FEEL WE SHOULD KNOW:_____

_____

_____

_____

DO YOU SMOKE? ☐ YES ☐ NO QUANTITY:_____

The above information is correct to the best of my knowledge.

_____ _____

Signature of patient or responsible party Date