



PATIENT MEDICAL HISTORY FORM

Patient: _____

Date: _____

1. What is your primary problem? _____
2. Do you have any secondary problems? _____
3. How did your problem begin? _____
- _____
4. When did your problem begin? _____
5. Have you had surgery for your condition? _____
6. Have you had any diagnostic tests (i.e. XRays, MRI, EMG, etc.)? Please list date/location/results _____
- _____
7. Have you had anything similar before? NO ___ YES ___ If yes, tell me about it: _____
- _____
8. What is your occupation/hobby? _____
9. Are you working? YES ___ NO ___ If no, is it because of your problem? YES ___ NO ___
10. What job duties do you perform? _____
11. Are you on restricted duty? YES ___ NO ___
12. Just prior to this onset, were you completely free of symptoms? YES ___ NO ___

Have you ever had any of the following conditions? Please explain all YES answers in the space provided below:

	YES	NO		YES	NO
ASTHMA			GOUT		
CANCER			OPEN HEART SURGERY		
DIABETES			ARTHRITIS		
HEART DISEASE			TUBERCULOSIS		
HEPATITIS			FRACTURES		
HIGH BLOOD PRESSURE			EPILEPSY/SEIZURES		
SKIN CONDITIONS			DISLOCATIONS/JOINT PROBLEMS		
STROKE			PACEMAKER		
THYROID PROBLEM			OTHER HEALTH PROBLEMS		

Please explain all YES answers: _____

Do you have any allergies? NO ___ YES ___ If yes, please list: _____

Please list any hospitalizations/surgeries: _____

Women Only: Are you pregnant? NO ___ YES ___

Hand Dominance Left Right