

PAST MEDICAL HISTORY FORM

Patient Name: _____

Date: ____/____/____

Are you presently working? Yes No Date of next physician's visit: ____/____/____

1. Date of injury/onset: ____/____/____

2. Have you ever had these symptoms before? Yes No

3. Check which apply to your current condition: work-related injury recurrence of previous injury
 motor vehicle accident injury related to lifting injury related to falling
 cause unknown athletic/recreational injury Other: _____

4. Have you had a related surgery? Yes No

5. If female, are you pregnant? Yes No

6. Do you have, or have you had any of the following:

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Skin Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	ringing in your ears	<input type="checkbox"/>	<input type="checkbox"/>
Urine Leakage	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Smoking	<input type="checkbox"/>	<input type="checkbox"/>
Liver/Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

If you answered Yes to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

7. Do you have any allergies? Yes No

If yes, please list your allergies: _____

8. Are you presently taking any medication? Yes No

If yes, please list what medications and for what condition: _____
