Medical Report

Name : _____ Date : _____

When did your problem start? : _____ Describe Problem : _____

Cause of Current Problem :

☐ Car Accident ☐ Work injury ☐ Gradual onset ☐ Other

Did this Problem require Surgery : ☐ No ☐ Yes ☐ Yes Date of Surgery

Past Medical History Do you have a history of the following problems?

☐ Breathing Problems	☐ Stroke	☐ Depression
☐ Pregnant	☐ Bone/joint Problems	☐ Bowel/Bladder
☐ Heart Problems	☐ Kidney Problems	☐ History of heavy alcohol use
☐ Current Wound/Skin Problems	☐ Gallbladder/Liver	☐ Drug use
☐ Pacemaker	☐ Electrical implants	☐ Smoking
☐ Tumor/Cancer	☐ Anxiety attacks	☐ Headaches
☐ Diabetes	☐ Sleep Apnea	

☐ No Surgeries

Surgeries/Hospitalizations	Year	Complications

☐ No Medication

Medications Please list Medications that you are taking.

Medication(s)	Dose	Reason for Medication

☐ No Known allergies

Allergies

Latex ☐ Yes ☐ No Iodine ☐ Yes ☐ No Bromine ☐ Yes ☐ No

Other _____

Do you have any religious/cultural views that will affect your treatment? ☐ No ☐ Yes

Additional comment(Reading or Memory Problem) _____

Signature _____ Date _____