**Medical History Form**

**The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.**

**PLEASE PRINT**

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| Name: |  | | | | | Phone # (H) | | |  | | (B) |  | | |
| Address: | |  | | | | | | | | | | | | |
| Date of Birth: | | |  | | Occupation: | |  | | | Source of referral | | |  | |
| What is your chief complaint? | | | |  | | | | How is your health in general? | | | | | |  |

Please indicate conditions you are experiencing or have experienced:

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| **HEAD**  headaches  migraines  vision problems/loss  earaches/hearing loss  jaw problems  **RESPIRATOR**  smoking  chronic cough  emphysema  asthma  bronchitis  shortness of breath  **CARDIOVASCULAR**  high blood pressure  low blood pressure  chronic congestive heart failure  history of heart disease/MI  phlebitis/varicose veins  stroke/CVA  pacemaker or similar device  heart attack   |  |  | | --- | --- | | other: |  |   **WOMEN**   |  |  |  | | --- | --- | --- | | pregnant, due: | |  | | gynecological conditions, | | | | what? |  | | | **MUSCLES/JOINTS**  neck  mid-back  lower back  shoulders  leg: left/right   |  |  | | --- | --- | | other: | M | |  | | |  | |   **INFECTIONS**  (*Hepatitis, TB, HIV, AIDS and other*)   |  | | --- | |  | |  |   **SKIN CONDITIONS**   |  | | --- | |  | |  |   **SURGERY**   |  |  |  | | --- | --- | --- | | type: |  | | | date: |  | | | current symptoms: | | M | |  | | |   **INJURY**   |  |  |  | | --- | --- | --- | | type: |  | | | date: |  | | | current symptoms: | | M | |  | | | | **OTHER CONDITIONS**  digestive problems  constipation  epilepsy  loss of sensation  liver/gall bladder problems  kidney problems  diabetes  allergies/hypersensitivity reaction  cancer  arthritis  hemophilia  osteoporosis  mental illness  internal pins, wires, artificial joints  or special equipment   |  |  | | --- | --- | | where? |  | | other: | |   **CURRENT MEDICATION**   |  | | --- | | name use | | M | |  | |  | |  |   **MEDICAL DOCTOR**   |  |  | | --- | --- | | Name: |  | | Address: |  | | Phone #: |  | |

I understand that information I give on this form will be confidential and will be used for no other purpose than medical professional’s clinical records. The information given by me on this form is accurate to the best of my knowledge, and I understand that will be used by the medical professional in determination of treatment is appropriate for me, it is my responsibility to update this information as it changes.

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| --- | --- | --- | --- |
| Date: |  | Signature: |  |