

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?

- | | | |
|--|--|---|
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Bone/joint Problems | <input type="checkbox"/> Bowel/Bladder |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> History of heavy alcohol use |
| <input type="checkbox"/> Current Wound/Skin Problems | <input type="checkbox"/> Gallbladder/Liver | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Electrical implants | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Tumor/Cancer | <input type="checkbox"/> Anxiety attacks | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> 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 _____