MEDICAL HISTORY

Patient Name____ Age____________________

Reason for Visit__________________________Right Left Both Date of Injury ___________

Any recent MRI's ________________________Which is your dominate hand? Right Left

Primary Care Physician____

Please check if you have or had any of the following:

____Diabetes
____Numbness
____Poor Circulation
____Heart Disease
____Hardening of the Arteries
____Raynaud's Disease
____Varicose Veins
____Phlebitis
____Blood Clots (DVT)
____Ankle Swelling
____Lupus/Scleroderma
____Anemia
____High Blood Pressure
____High Cholesterol
____Low Thyroid

____Kidney Trouble
____Liver Trouble/Hepatitis
____Tuberculosis
____ Stomach Ulcers
____Asthma/Emphysema
____Gout
____Blood Disease
____Cancer (type) __________________
____Epilepsy
____Osteoarthritis
____Rheumatoid Arthritis
____In a risk group for Aids
____Have AIDS or HIV Positive
____Broken Bones _____________
____Allergic to Metal/Latex

PREVIOUS OPERATIONS/FRACTURES:____

CURRENT MEDICATIONS:____

KNOWN DRUG ALLERGIES:____

HEALTH PROBLEMS THAT RUN IN THE FAMILY:____
____

DO YOU DRINK ALCOHOLIC BEVERAGES:_______________HOW MANY PER DAY:_________
HAVE YOU EVER SMOKED? _______HOW MANY PACKS PER DAY? _______
HOW MANY YEARS? ________ DATE QUIT? _________________
LEG CRAMPING DURING THE NIGHT? ________________OR WHEN WALKING?_________________

PATIENT SIGNATURE:____