Past Medical History Form

Patient Name:___________________________________ **Date**:_______________________________________

Are you presently working? Yes____ No____ **Date of next physician's visit**:____________________

1. **Date of injury or onset of symptoms**:____

2. **Have you ever had these symptoms before?** Yes_____ No_____

3**. Check which apply to your symptoms**:

___ **work related injury** ___ **recurrence of previous injury**

___ **motor vehicle accident** ___ **injury related to lifting**

___ **cause unknown** ___ **athletic/recreational injury**

___ **other**:____

4**. Have you had a related surgery**? ___Yes ___No

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

Diabetes	___Yes ___No	**Allergies to Aspirin**	___Yes ___No
Chest Pain/Angina	___Yes ___No	**Allergies to Heat**	___Yes ___No
High Blood Pressure	___Yes ___No	**Allergies/Poor Tolerance to cold**	___Yes ___No
Heart Disease	___Yes ___No	**Other Allergies**	___Yes ___No
Heart Attack	___Yes ___No	**Hernia**	___Yes ___No
Heart Palpatations	___Yes ___No	**Seizures**	___Yes ___No
Pacemaker	___Yes ___No	**Metal Implants**	___Yes ___No
Headaches	___Yes ___No	**Dizziness/Fainting**	___Yes ___No
Kidney Problems	___Yes ___No	**Recent Fractures**	___Yes ___No
Are you pregnant?	___Yes ___No	**Surgeries**	___Yes ___No
Cancer	___Yes ___No	**Skin Abnormalities**	___Yes ___No
Bowel/ Bladder Abnormalities	___Yes ___No	**Sexual Dysfunction**	___Yes ___No
Asthma/Breathing Difficulties	___Yes ___No	**Nausea/Vomiting**	___Yes ___No
Liver/Gallbladder Problems	___Yes ___No	**Ringing in your ears**	___Yes ___No
Other	___Yes ___No	**Rheumatoid**	___Yes ___No
Smoking	___Yes ___No	**Special Diet Guidelines**	___Yes ___No

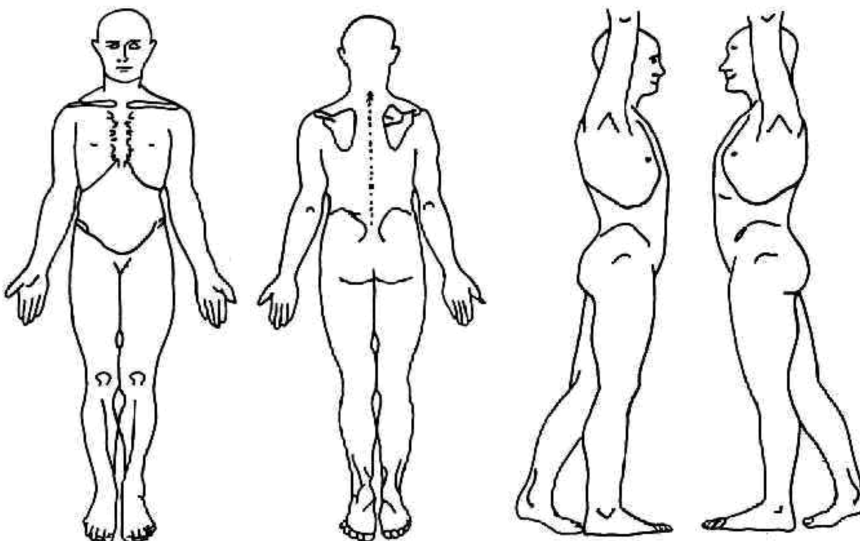
If you marked yes to any of the above, please briefly Explain and give approximated date/s:___________
____
____
____
____

Is there any other information regarding your past Medical history that we should know about? ______
____
____
____
____

Are you currently taking any medications?
___Yes ___No **If yes, please list**:_____________
____
____
____

6. **Rate the intensity of pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible:** __________________.

10. Please indicate below where your pain is located.



8. **In the rare instance of an emergency who should we contact**?_____________________________________ __________________________
Name phone number

9. **Do you participate in any sports, exercise programs, or activities on a regular basis?** ____Yes ____No

____ ____ ______________________________
Signature relationship to patient Date