GENERAL MEDICAL HISTORY

Date: ___________________________

Please fill this out as accurately as you can, the doctor *does* read it.

Name: _________________________________ Date of Birth: ____ / ____ / _______

Who referred you here? ____

Who is your Primary Doctor? ____________________________________ [ ] None

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Height: _______ Weight: ________; I am [ ] Right Handed; [ ] Left Handed

Do you smoke? [ ] No; [ ] Yes; __________ Packs a day for __________ years

Do you drink? [ ] No; [ ] Yes; __________ drinks a week

Do you live with family? ____

What do you do for a living? ____

Allergies: ____

List *all* medications you are taking now: ______________________________

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Do you have, or ever had, any of the following medical conditions:

[ ] Arthritis [ ] Bone Infection [ ] Osteoporosis

[ ] Heart Disease [ ] High Blood Pressure [ ] Vascular disease [ ] Stroke

[ ] Blood clots [ ] Easy bruising or bleeding

[ ] Asthma [ ] COPD/Lung Disease [ ] Sleep Apnea

[ ] Stomach Ulcers [ ] Intestinal Disease [ ] Acid Reflux

[ ] Diabetes [ ] Thyroid Disease

[ ] Hepatitis [ ] HIV/AIDS [ ] Cancer

[ ] Liver Disease [ ] Kidney Disease [ ] Anemia

[ ] Drug dependency [ ] Alcohol Dependency [ ] Anxiety / Depression

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[ ] *other* medical conditions:

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Have you had any *surgery or procedures?*

Surgery	Year	Surgery	Year
[ ] Heart Bypass	____________	[ ] Heart catheterization	____________
[ ] Stent placement	____________	[ ] Bone fixation	____________
[ ] Hip surgery	____________	[ ] Shoulder	____________
[ ] Knee	____________	[ ] Arm	____________
[ ] Ankle	____________	[ ] Wrist	____________

[ ] *other* surgeries and dates:

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