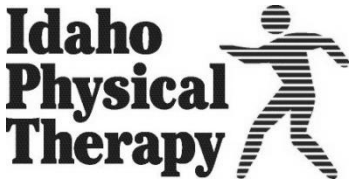
Patient Medical History Questionnaire



Circle "Yes" or "No" as applicable. Have you ever had:

Cardiac Pacemaker	**YES**	**NO**	**Kidney Disease**	**YES**	**NO**
Heart Attack	**YES**	**NO**	**Seizures**	**YES**	**NO**
Angina/Chest Pains	**YES**	**NO**	**High Blood Pressure**	**YES**	**NO**
Emphysema/COPD	**YES**	**NO**	**Low Blood Pressure**	**YES**	**NO**
Cancer	**YES**	**NO**	**Shortness of Breath**	**YES**	**NO**
Stroke	**YES**	**NO**	**Chronic/Frequent Cough**	**YES**	**NO**
Diabetes	**YES**	**NO**	**Depression**	**YES**	**NO**
Blackouts	**YES**	**NO**	**Indigestion/Ulcers**	**YES**	**NO**
Blurred/Double Vision	**YES**	**NO**	**Tuberculosis**	**YES**	**NO**
Nervousness/Anxiety	**YES**	**NO**	**Blood Clot**	**YES**	**NO**
Asthma	**YES**	**NO**	**Allergies**	**YES**	**NO**
Hernia	**YES**	**NO**	**Gout**	**YES**	**NO**
Unexplained Weight Loss/Gain	**YES**	**NO**	**Are you now pregnant or do you**		
Liver Disease	**YES**	**NO**	**suspect you might be?**	**YES**	**NO**

For <u>all conditions</u> in which a "Yes" was indicated above, please give dates and details below: _____

_____

_____

Do you have any other medical problems which are not listed here (including any recent surgeries)? _____

_____

_____

List current medications and dosages (include over-the-counter meds & vitamins):_____

_____

Your Height _____ Your Weight _____

Do you consume alcohol? *Yes* *No* If "Yes," how many drinks per day/week? _____
Do you smoke? *Yes* *No* If "Yes," how many packs per day/week? _____

Is the injury/condition you are seeking treatment for today due to an accident?	**YES**	**NO**
Is this injury/condition part of a workers' comp claim?	**YES**	**NO**
Is this injury/condition due to a motor vehicle accident? - **If YES, please list the state in which the accident took place:**	**YES**	**NO**

Date of Accident (if applicable): _____

I certify to the best of my knowledge that the above answers are true and correct.

Patient Signature _____ Date _____