

# Medical History

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

1. Are you generally in good health?  Yes  No

If no, please explain \_\_\_\_\_

2. Are you currently seeing a physician or other health care practitioner?  Yes  No

If yes, please explain \_\_\_\_\_

**Do you have a history of:**

- |                         |                              |                             |                                 |                              |                             |
|-------------------------|------------------------------|-----------------------------|---------------------------------|------------------------------|-----------------------------|
| Tiring easily, weakness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Marked weight change    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis (T.B.)             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High/Low blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | AIDS/ARC                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart disease           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bleeding disorders              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart attack            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pacemaker               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Arthritis                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney problems         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mental illness          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Allergies to cold/heat          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Claustrophobia          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other allergies                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Previous surgery                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rheumatic fever         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Metal implants                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dizziness               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hernia (Ventral, Inguinal, etc) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Headaches               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Women-Are you pregnant?         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

3. Do you have any other medical condition(s) we should be aware of?  Yes  No

If yes, please explain \_\_\_\_\_

4. Have you been hospitalized within the last five years?  Yes  No

If yes, for what condition(s)? \_\_\_\_\_

5. Have you ever experienced any reaction to any of the following medications?

- Aspirin       Penicillin       Cortisone       Novacaine       Xylocaine

What medications are you presently taking? \_\_\_\_\_

6. Do you smoke?  Yes  No? If yes, how much on a daily basis? \_\_\_\_\_

7. Have you had x-rays, MRI or other special test(s) done for your present condition?  Yes  No

If yes, please explain \_\_\_\_\_

**Where is your pain or symptoms? Please mark on the drawings below the areas of your pain/symptoms.**

