MEDICAL HISTORY

DATE_____PATIENT NAME_____ AGE_____

HT ____ '____ " WT_____ (Please Circle) MALE/FEMALE MARRIED/SINGLE LEFT/RIGHT-HANDED

TYPE OF WORK YOU DO_____

WHAT PROBLEM(S) BRING YOU TO THE DOCTOR_____

WHEN DID THE PROBLEM(S) START_____IS/ARE PROBLEM(S)GETTING WORSE_____

WAS THERE AN ACCIDENT OR INJURY_____WAS IT WORK-RELATED_____

WHAT DOCTORS HAVE YOU SEEN FOR THE PROBLEM(S) _____

HAVE YOU EVER BEEN HOSPITALIZED_____DATE(S)_____ WHERE_____
_____ _____

LIST SURGERIES YOU HAVE HAD AND DATES_____
_____

LIST ANY MAJOR ILLNESSES YOU HAVE_____

LIST ALL MEDICATIONS (WITH DOSE) YOU ARE PRESENTLY TAKING_____
_____

LIST ANY ALLERGIES TO MEDICATIONS_____

ARE THERE ANY DISEASES WHICH RUN IN YOUR FAMILY_____

DO YOU SMOKE_____HOW MANY PER DAY_____

DO YOU DRINK ALCOHOLIC BEVERAGES_____HOW MUCH_____ HOW OFTEN_____

WHEN WAS YOUR LAST CHEST XRAY_____EKG_____BLOOD TESTS_____

PLEASE "X" IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

_____HEART ATTACK	_____HEART PROBLEMS	_____HIGH BLOOD PRESSURE
_____STROKE	_____SEIZURES	_____BLEEDING DISORDER
_____DIABETES	_____ANY LUNG PROBLEMS	_____ASTHMA
_____EMPHYSEMA		

PATIENT SIGNATURE_____