

Medical History (page two)

Name (Please print in ink throughout this form)

Date

9. Has anyone in your family ever had the same or similar problem?
(Please list who and what type of problem.)
10. If your symptoms are related to any injury, please mark the box below indicating the type of injury. **Date** of injury: _____

auto injury personal injury work-related injury other _____

Describe the accident and injury **completely**. If work-related, please tell why.

11. Are you working now? What are the physical requirements of your job? (Describe what you do physically during your work day.)

Specifically, what amount and kind of lifting, if any, are you required to do?

Do you have any medical work-related restrictions? (Please describe.)

12. If you stopped working because of symptoms related to this injury, when did you stop working?

13. Why did you stop working?

14. Please list all current medications and the reason (diagnosis) for taking them.

Medication**Reason for taking medication**

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

My preferred pharmacy is: _____

Area code and phone number

Medical History (page three)

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Date

15. Do you take ASPIRIN, MOTRIN, IBUPROFEN, NAPROSYN, RELAFEN, ORUVAIL, ADVIL, or any other anti-inflammatory medicine? If so, please list.
16. Do you take COUMADIN (WARFARIN), PLAVIX, or any other blood thinners? yes no
If so, please list.
17. Do you take any supplements, herbs, or vitamins? If so, please list.
18. Have you ever had any brain or spine surgery? yes no
If so, please give dates, reasons, and name(s) of surgeon(s).
19. Please list **ANY** other past operations you have undergone during the last 10 years.
Please give dates if you remember them. No other surgeries in the past 10 years.
- A. _____ C. _____
B. _____ D. _____
20. Please list **ANY** medication ALLERGIES. No known allergies
- A. _____ C. _____
B. _____ D. _____
21. Are you allergic to IODINE? yes no don't know
22. Are you allergic to LATEX? yes no don't know
23. Do you smoke? If so, how much?
24. Do you drink alcohol? If so, how much? What kind?
25. Please state:
Height: _____
Weight: _____
Date of birth: _____