Past Medical History Questionnaire

Patient Name_____ DOB_____

How did you hear about us?

_____Former/returning patient _____Word of Mouth _____ Location/sign _____Facebook

_____ Google _____ Doctor _____ Other. If other, please specify below:

_____

Do you now or have you ever had any of the following:

Arthritis	_____	Metal Implants	_____
Osteoporosis	_____	Cancer/Tumor	_____
High Blood Pressure	_____	Recent Weight Loss/Gain	_____
Heart Disease	_____	Current Infection(s)	_____
Heart Attack	_____	Tuberculosis	_____
Pacemaker	_____	Hepatitis	_____
Vascular Disease	_____	Thyroid Problems	_____
Stroke	_____	Headaches	_____
Asthma	_____	Head Injury/Concussion	_____
Shortness of Breath	_____	Hernia	_____
Chronic Cough	_____	Kidney/Bladder Problems	_____
Fainting Spells	_____	Previous Fractures	_____
Diabetes	_____	Previous Surgeries	_____
Anemia	_____	Hearing Loss	_____
Hypersensitivity		Depression	_____
to heat/cold	_____	Anxiety	_____
Swelling in Ankles	_____	Substance Abuse	_____
Seizures/Epilepsy	_____	Allergies	_____
Deep Vein Thrombosis	_____	Other	_____

Could you be or are you pregnant? *YES* *NO*

Have you had one or more falls in the past year? *YES* *NO*

If you answered "yes" to any of the above, please explain and give approximate date(s):

_____

_____

Are you presently taking any medications? If "yes", list all medications.

_____

_____

The information above is correct to the best of my knowledge.

_____ _____

Patient/Parent/Guardian Signature Date