



Patient Medical Profile

Patient Name : _____ Age: _____
 Who may we thank for referring you to us? _____
 Primary care physician (if different): _____
 Reason for visit: _____
 Date of injury / Onset of problem: _____

CURRENT HEALTH

Please list any medical problems you have or have been diagnosed with: **NO PROBLEMS** Height: _____
 Weight: _____

<input type="checkbox"/> Heart disease or attack	<input type="checkbox"/> Stroke	<input type="checkbox"/> Osteoporosis / Low Bone Density
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Stomach ulcers
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Heartburn / Reflux
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> DVT (Blood clot)	<input type="checkbox"/> Gout / Psedogout
<input type="checkbox"/> COPD / Emphysema	<input type="checkbox"/> Chronic headaches	<input type="checkbox"/> Depression

Please list other medical problems:

Females Only: Date of last menstrual period: _____ Currently Pregnant? Yes No Possibly

SURGICAL HISTORY

Please list all previous surgeries and the approximate year: **I HAVE NOT HAD ANY SURGERIES**

Surgery:	Year:	Surgery:	Year:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have allergies or any problems with anesthesia? No Yes Describe: _____

MEDICATIONS

Please list any medication you currently use, including over-the-counter medications, vitamins, and supplements::

I TAKE NO MEDICATION

ALLERGIES

NO KNOWN DRUG ALLERGIES

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex
<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Diagnostic Dyes	<input type="checkbox"/> Adhesive Tape

Other: _____

FAMILY HISTORY

Does anyone in your immediate family (parents, brothers, sisters, children) have any of the following? **NONE**

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout	<input type="checkbox"/> Hip Problems	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Lupus	<input type="checkbox"/> Back Disc Problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Asthma	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Psoriasis	

