# MEDICAL HISTORY FORM

Name: ______________________________________________ Today's Date: ________________

Primary Physician & Telephone #: _____________________________________________________

What part of the body are you being seen for today? ______________________________________

Do you have an allergy to latex? ○ yes ○ no

## Past Medical History

| | | |
|---|---|---|
| ○ Diabetes | ○ High Blood Pressure | ○ Skin rashes |
| ○ Syncope | ○ Low Blood Pressure | ○ Psoriasis |
| ○ Osteoporosis | ○ Shortness of Breath | ○ HIV/AIDS |
| ○ Gout | ○ Heart Problems | ○ Hepatitis |
| ○ Lupus | ○ Degenerative Arthritis | |

○ Cancer, specify type and treatment _____________________________________________

○ Other __________________________________________________________________________

## Social History

Are you currently smoking? ○ yes ○ no ○ never smoked

If yes, how many cigarettes do you smoke per day? ________________

Do you have a Pacemaker? ○ yes ○ no

Are you currently taking any medications? ○ yes ○ no

If yes, what type of medications are you taking? __________________________________________

__________________________________________________________________________________

I certify that this information is correct to the best of my knowledge

__________________________________________________________ ____________________

Patient or Guardian Signature/Relationship if not self Date