Medical History Questionnaire

Name: ______________________ Age: _____ Occupation: ______________________

Reason for Visit: ______________________ Date of Onset: _____________________

Describe your symptoms: ____

____

Please list any previous surgeries and dates: ____

____

Please list current medications or attach a copy of list: __________________________________

____

Do you have latex allergies: Yes _____ No ______

Do you have a: Defibrillator ________ Pacemaker _________

Are you Pregnant: Yes ____ No ___ Do you use Tobacco Products: Yes ______ No _______

Please check if you have been diagnosed, treated for, or have a history of the following:

High Blood Pressure	□	Heart Attack	□
Heart Failure	□	Stroke	□
Osteoarthritis	□	Rheumatoid Arthritis	□
Lupus	□	Asthma	□
Emphysema	□	Bowel/Bladder Incontinence	□
Cancer (specify): _______________		Seizures	□
Fracture (specify):_______________		Tuberculosis	□
Anemia	□	Hepatitis	□
Fibromyalgia	□	Diabetes	□
Blood Clots	□	Hernia	□
Osteoporosis	□	Other: _______________________	
Atrial Fibrillation	□	_______________________________	

Please rate your pain at its best, worst, and average level during the last week on a scale from 0 (no pain) to 10 (pain is so bad that you need to go to the emergency room).

Best _____ Worst ______ Average _______