



PAST MEDICAL HISTORY FORM

Patient Name:

Today's date:

Date of Injury:

Have you ever had these symptoms before? YES / NO

Cause of injury:

Have you had a related surgery? YES / NO

Do you have or have you had any of the following?

	Yes	No		Yes	No
Diabetes	Y	N	Allergies to Aspirin	Y	N
Chest Pain / Angina	Y	N	Allergies to Heat	Y	N
High Blood Pressure	Y	N	Allergies / Poor tolerance to Cold	Y	N
Heart Disease	Y	N	Other Allergies	Y	N
Heart Attack	Y	N	Hernia	Y	N
Heart Palpitations	Y	N	Seizures	Y	N
Pacemaker	Y	N	Metal Implants	Y	N
Headaches	Y	N	Dizziness / Fainting	Y	N
Kidney Problems	Y	N	Recent Fractures	Y	N
Are you pregnant?	Y	N	Surgeries	Y	N
Cancer	Y	N	Skin Abnormalities	Y	N
Osteoporosis	Y	N	Sexual Dysfunction	Y	N
Bowel / Bladder Abnormalities	Y	N	Nausea / Vomiting	Y	N
Urine Leakage	Y	N	Ringling in your ears	Y	N
Asthma / Breathing Difficulties	Y	N	Rheumatoid Arthritis	Y	N
Liver / Gallbladder Problems	Y	N	Special Diet Guidelines	Y	N
Smoking	Y	N	Hypoglycemia	Y	N
Other / Specify	Y	N	Stroke / CVA	Y	N

Are you presently taking Medication? YES / NO
 If yes, please list what medications and for what condition.
