Please complete below this line

Have you ever been tested for Tuberculosis? ______ Results Pos:_______ Neg: _______

Past Medical History:

Have you ever had any of the following? (check all that apply)

__ Heart Attack-Angina	__ Cancer	__ Seizures/Convulsions	__ Osteoarthritis
__ Heart Disease, Murmur or Heart Failure	__ Emphysema	__ Bleeding Tendencies	__ Hepatitis (Specify)
	__ Tuberculosis	__ Glaucoma/Eye Disease	__ Hepatitis (Unknown)
__ High Blood Pressure	__ Kidney Disease	__ Asthma/Hay Fever	__ Ankylosing Spondylitis
__ Diabetes	__ Liver Disease	__ Migraines	__ Gall Stones
__ Stroke	__ Cirrhosis	__ Phlebitis (Blood Clot)	__ Pneumonia
__ Prostate Problems	__ Gout	__ Osteoporosis	__ Arthritis (Type)
__ Prostate Cancer	__ Anxiety	__ Lupus	__ Arthritis (Childhood)
__ HIV	__ Depression		__ Arthritis (Rheumatoid)

__ Fractures (Specify) ____

____

SOCIAL HISTORY

__ Smoking Habit

__ Alcohol Use

__ Substance Abuse

FAMILY HISTORY (Any of the above apply)

Mother ____

Father ____

Check the following surgeries you have had

__ Hip Replacement	__ Neck	__ Tonsils/Adenoids
__ Knee Replacement	__ Back	__ Breast
__ Arthroscopy	__ Appendectomy	__ Carpal Tunnel
__ Torn Cartilage	__ Hysterectomy	__ Eye/Cataracts
__ Hand	__ Hernia	__ Cystoscopy
__ Foot/Bunion	__ Gallbladder	__ Ulcer (Stomach)
__ Other (Specify)		__ D&C

DO YOU HAVE OR HAVE YOU EVER HAD ANY METAL IN YOUR BODY?*

Explain: ____

Drug Allergies? Yes___ No___ Do you have an allergy to METAL/JEWELRY? Yes __ No __**

Drug/Metal Allergies ____

List Current Medications:

1. ______________________ 3. ______________________ **Use other side if necessary**

2. ______________________ 4. ______________________

PHARMACY NAME: ______________________________ PHONE#: ____________________

Patient Signature ______________________________________ Date ____________________

PHYSICIAN SIGNATURE __________________________________ DATE ____________________

DO NOT COMPLETE (OFFICE USE)

****

*Date first seen: ________________ Name: ______________________________________

*Chief Complaint:

____

________________________*Accident? Yes ___ No ___ DOI/on set Date: ______________________

*Place of accident, State? ______________________ Height: ________________________

*Contact Physician __________________________ Weight: ________________________

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