

MEDICAL INFORMATION SHEET

Patient Name: _____ Age: _____ Date of Visit: _____

Present Complaint: _____

PRIMARY CARE PHYSICIAN'S NAME _____

PHONE _____

Please check any treatment that you have had for the current complaint:

MRI CTSCAN THERAPY XRAYs SURGERY OTHER

When did this injury occur: _____

How did this injury occur: _____

Was it related to a motor vehicle or work related injury _____

Past Medical History – Please check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Recurrent Infections | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> HIV/Aids |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other Communicable diseases |
| <input type="checkbox"/> Other _____ | | |

Do you have any allergies?

- Antibiotics/Mediations _____
- Surgical Tape
- Iodine/Shellfish
- Local or general Anesthesia
- Seasonal allergies
- Other _____

CURRENT MEDICATIONS: _____

PAST SURGICAL HISTORY _____

Who referred you to our practice?

Patient Primary Care Physician Another Physician Insurance Plan Online Directory

Patient's Signature _____