

General Health Information

(Please Print Clearly)

NAME _____ REFERRING PHYSICIAN _____
DATE OF BIRTH _____ HEIGHT _____
AGE _____ WEIGHT _____

REASON FOR VISIT: _____

IS CONDITION/INJURY WORK RELATED? YES NO

PAST MEDICAL HISTORY

Medical: Do you now have, or have you ever had, any of the following disorders?

- | | | |
|-----------------------------------------------|-----------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Anemia or other Blood Disorder |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Nerve Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Decreased Vision |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Dry Eye |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Excessive Tearing |
| <input type="checkbox"/> Other Lung Disease | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Wound Healing Problems |
| | | <input type="checkbox"/> Keloids or Excessive Scar Formation |

Any conditions or illnesses not listed above? _____

Surgical: Please list all operations you have had, including hospitals and dates, if known.

Medications: Please list all medications you are currently taking.

INCLUDE NAME, DOSAGE (mg., gm., etc.) and FREQUENCY.

(Include Aspirin, Birth Control Pills, Vitamins, Etc.)

Allergies: Drug Allergies (list) _____ Other: (tape, iodine, soaps, etc.) _____

Other: Do you smoke? _____ Approx. packs/day? _____ Do you drink? _____ Approx. amount/week? _____

List any diseases that run in your family: _____