

Medical History Form

Patient Name: _____ Latex Allergies: Yes ___ No ___ Topical Allergy: _____

Height: _____ ft _____ in Weight: _____ (pounds) Date of injury: _____

Diagnosis as stated to you by your physician: _____

How did this injury/ exacerbation occur? _____

Have you been hospitalized for the present condition? ☐ Yes ☒ No If Yes, date: _____

Have you had surgery for the present condition? ☐ Yes ☐ No If Yes, date: _____

If yes, surgery type: _____

Have you had any falls this past year? ☐ Yes ☐ No If Yes, how many? _____

Have you received previous treatment for this condition? ☐ Yes ☐ No If Yes, date: _____

If yes, please summarize: _____

Have you ever had any of the following? ☐ EMG ☐ CT SCAN ☐ MYELOGRAM ☐ MRI ☐ XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Acquired Respiratory Distress Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety or Panic Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis (RA, OA)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congestive Heart Failure (CHF)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Degenerative Disc Disease (back disease, spinal stenosis, severe chronic back pain)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Peripheral Vascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke or TIA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Visual Impairment (cataracts, glaucoma, macular degeneration)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bowel / Bladder Abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizzy or Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy or Seizure Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fracture	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis A, B, C	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypoglycemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Immunosuppressant Condition or Medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver / Gallbladder Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Metal Implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea / Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ringing in Your Ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexual Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin Abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Special Diet Guidelines	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Sample Primary Care Medical History Template

JR Anderson



Sample Primary Care Medical History Template:

The book delves into Sample Primary Care Medical History Template. Sample Primary Care Medical History Template is a crucial topic that must be grasped by everyone, ranging from students and scholars to the general public. This book will furnish comprehensive and in-depth insights into Sample Primary Care Medical History Template, encompassing both the fundamentals and more intricate discussions.

1. The book is structured into several chapters, namely:
 - Chapter 1: Introduction to Sample Primary Care Medical History Template
 - Chapter 2: Essential Elements of Sample Primary Care Medical History Template
 - Chapter 3: Sample Primary Care Medical History Template in Everyday Life
 - Chapter 4: Sample Primary Care Medical History Template in Specific Contexts
 - Chapter 5: Conclusion
 2. In chapter 1, this book will provide an overview of Sample Primary Care Medical History Template. This chapter will explore what Sample Primary Care Medical History Template is, why Sample Primary Care Medical History Template is vital, and how to effectively learn about Sample Primary Care Medical History Template.
 3. In chapter 2, the author will delve into the foundational concepts of Sample Primary Care Medical History Template. This chapter will elucidate the essential principles that must be understood to grasp Sample Primary Care Medical History Template in its entirety.
 4. In chapter 3, this book will examine the practical applications of Sample Primary Care Medical History Template in daily life. The third chapter will showcase real-world examples of how Sample Primary Care Medical History Template can be effectively utilized in everyday scenarios.
 5. In chapter 4, this book will scrutinize the relevance of Sample Primary Care Medical History Template in specific contexts. This chapter will explore how Sample Primary Care Medical History Template is applied in specialized fields, such as education, business, and technology.
 6. In chapter 5, the author will draw a conclusion about Sample Primary Care Medical History Template. This chapter will summarize the key points that have been discussed throughout the book.
- The book is crafted in an easy-to-understand language and is complemented by engaging illustrations. It is highly recommended for anyone seeking to gain a comprehensive understanding of Sample Primary Care Medical History Template.

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