

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

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

Sample Primary Care Medical History Template

Liying Dong



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1. Understanding the eBook Sample Primary Care Medical History Template
 - The Rise of Digital Reading Sample Primary Care Medical History Template
 - Advantages of eBooks Over Traditional Books
2. Identifying Sample Primary Care Medical History Template
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Sample Primary Care Medical History Template
 - User-Friendly Interface
4. Exploring eBook Recommendations from Sample Primary Care Medical History Template
 - Personalized Recommendations
 - Sample Primary Care Medical History Template User Reviews and Ratings
 - Sample Primary Care Medical History Template and Bestseller Lists
5. Accessing Sample Primary Care Medical History Template Free and Paid eBooks
 - Sample Primary Care Medical History Template Public Domain eBooks
 - Sample Primary Care Medical History Template eBook Subscription Services
 - Sample Primary Care Medical History Template Budget-Friendly Options
6. Navigating Sample Primary Care Medical History Template eBook Formats

- ePub, PDF, MOBI, and More
- Sample Primary Care Medical History Template Compatibility with Devices
- Sample Primary Care Medical History Template Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Sample Primary Care Medical History Template
 - Highlighting and Note-Taking Sample Primary Care Medical History Template
 - Interactive Elements Sample Primary Care Medical History Template
- 8. Staying Engaged with Sample Primary Care Medical History Template
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Sample Primary Care Medical History Template
- 9. Balancing eBooks and Physical Books Sample Primary Care Medical History Template
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Sample Primary Care Medical History Template
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Sample Primary Care Medical History Template
 - Setting Reading Goals Sample Primary Care Medical History Template
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Sample Primary Care Medical History Template
 - Fact-Checking eBook Content of Sample Primary Care Medical History Template
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
- 14. Embracing eBook Trends
 - Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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