

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

Lorraine Loretz



Sample Primary Care Medical History Template:

Reviewing **Sample Primary Care Medical History Template**: Unlocking the Spellbinding Force of Linguistics

In a fast-paced world fueled by information and interconnectivity, the spellbinding force of linguistics has acquired newfound prominence. Its capacity to evoke emotions, stimulate contemplation, and stimulate metamorphosis is truly astonishing. Within the pages of "**Sample Primary Care Medical History Template**," an enthralling opus penned by a very acclaimed wordsmith, readers embark on an immersive expedition to unravel the intricate significance of language and its indelible imprint on our lives. Throughout this assessment, we shall delve into the book's central motifs, appraise its distinctive narrative style, and gauge its overarching influence on the minds of its readers.

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Table of Contents Sample Primary Care Medical History Template

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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