

## MEDICAL HISTORY

**NAME** \_\_\_\_\_

Are you generally in good health? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please explain \_\_\_\_\_

Are you currently seeing a physician or other health care practitioner? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_

**DO YOU HAVE A HISTORY OF:**

	Yes	No		Yes	No
Tiring easily, weakness	_____	_____	Cancer	_____	_____
Marked weight change	_____	_____	Tuberculosis (T.B.)	_____	_____
Diabetes	_____	_____	AIDS/ARC	_____	_____
High/Low Blood Pressure	_____	_____	Bleeding Disorders	_____	_____
Heart Disease	_____	_____	Hepatitis	_____	_____
Heart Attack	_____	_____	Rheumatic Fever	_____	_____
Pacemaker	_____	_____	Arthritis	_____	_____
Kidney Problems	_____	_____	Thyroid	_____	_____
Mental Illness	_____	_____	Allergies to Cold/Heat	_____	_____
Claustrophobia	_____	_____	Other Allergies	_____	_____
Asthma	_____	_____	Previous Surgery	_____	_____
Dizziness	_____	_____	Metal Implants	_____	_____
Headaches	_____	_____	Hernia (Ventral, Inguinal, ect)	_____	_____
Women – Are you pregnant	_____	_____			

Do you have any other medical condition(s) we should be aware of? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Have you been hospitalized within the last five years? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, for what condition(s) \_\_\_\_\_

Have you ever experienced any reaction to any of the following medications:

Aspirin \_\_\_\_\_ Penicillin \_\_\_\_\_ Cortisone \_\_\_\_\_ Novacaine \_\_\_\_\_ Xylocaine \_\_\_\_\_

What medications are you presently taking? \_\_\_\_\_

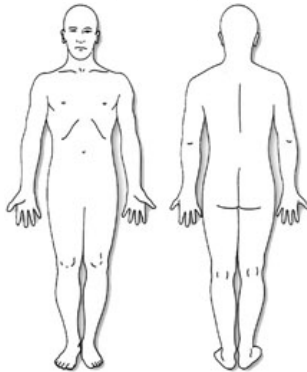
Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much on a daily basis? \_\_\_\_\_

Have you had any x-rays, MRI or other special test(s) done for your present condition? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_

**WHERE IS YOUR PAIN OR SYMPTOMS?**

Please mark on the drawings below the areas of your pain / symptoms.



**FOR WOMEN ONLY:**

When was the last time you saw a gynecologist? \_\_\_\_\_

Are you post-menopausal? \_\_\_\_\_

Do you have a family history of colon, breast or ovarian cancer? \_\_\_\_\_

DATE \_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_