Medical History Form

Have you had treatment for this problem? If yes, describe the treatment briefly. Employer:	Name:			Today's Date:	
How long have you had this problem?	Age			Height:	Weight:
Is this problem related to an injury? If yes, describe the injury briefly. (Is it work related) Is this problem related to a previous illness? If yes, describe the illness briefly If yes, describe the treatment briefly If yes, describe briefly If yes, describe your job briefly: If yes, describe briefly	State in your own words the	nature of your pre	oblem. (Briefly) _		
Is this problem related to a previous illness? If yes , describe the lilness briefly	How long have you had this problem?				Onset Date:
Have you had treatment for this problem? If yes, describe the treatment briefly					
Have you had treatment for this problem? If yes, describe the treatment briefly	Is this problem related to a p	revious illness? _	If ye	s , describe the illness	briefly.
Employer:	Have you had treatment for t				briefly.
Describe your job briefly: List allergies: List current medications: Coumadin Yes No Heprin Yes No Other meds: List previous surgical procedures: Have you had previous bone, joint, or muscle disorder or injury? If yes, describe briefly. Changes to your medical history conditions since your last admission: Diabetes Yes No Polio Yes No Hepatitis Yes No Cancer Stoke Yes No Hepatitis Yes No Cancer Site Yes No Hepatitis Yes N	Employer:				
List current medications: Coumadin Yes No Heprin Yes No Other meds:	Describe your job briefly:	a valent film and a second			
List current medications: Coumadin Yes No Heprin Yes No Other meds:	List allergies:	A MARAGEMENT CONTRACTOR CONTRACTO			
List previous surgical procedures:		umadin Yes No	Heprin Yes No	Other meds:	
Have you had previous bone, joint, or muscle disorder or injury? If yes, describe briefly Changes to your medical history conditions since your last admission: Diabetes	List previous surgical proced				
Diabetes					
Diabetes Yes No Polio Yes No Heart Disease No Hepatitis Yes No Hepat	Changes to your medical his	tory conditions s	ince your last adn	mission:	
Heart Disease Yes No Hepatitis Yes No Hepatitis Yes No High Blood Pressure Yes No Jaundice Yes No High Blood Pressure Yes No Arthritis Yes No Lung Disease, asthma Yes No Stroke Yes No Lung Disease, asthma Yes No No Neurological Disorder Yes No Kidney (Renal) Disease Yes No Cancer Site Yes No List there a history of any of the above diseases in your family? If so, which ones? Do you smoke? How much? If yes, how much daily/weekly. Female History: (for ultrasound purposes) Last monthly period Could you be pregnant? Yes No Additional information you may feel significant: With Whom do you live? Alone Spouse Child Other		 1			Yes No N
High Blood Pressure Yes No Jaundice Yes No Reheumatic Fever Yes No Arthritis Yes No Lung Disease, asthma Yes No Stroke Yes No Stroke Yes No Kidney (Renal) Disease Yes No Cancer Site Yes No Stering No Stroke Yes No Cancer Site Yes No Stroke Yes No No Stroke Yes No No Stroke Yes No Stroke Yes No Modditional information you may feel significant:	Heart Disease				
Rheumatic Fever Yes No Arthritis Yes No Dung Disease, asthma Yes No Dung Disease, asthma Yes No Dung Disease, asthma Yes No Dung Disease Yes No Disease	High Blood Pressure		ļ1		
Lung Disease, asthma Yes No No Neurological Disorder Yes No Cancer Site Yes No Madditional information you may feel significant: With Whom do you live? Alone Spouse Child Other					r
Tuberculosis Yes No Neurological Disorder Yes No Cancer Site Yes No Cancer Site Yes No Cancer Site Yes No Mo State No No State No State No No No Cancer Site No No State No State No No No No No Neurological Disorder Yes No No Cancer Site Yes No No State No No State No	Lung Disease, asthma	Yes			
Kidney (Renal) Disease Yes No Cancer Site Yes No State No No Additional information you may feel significant: With Whom do you live? Alone Spouse Child Other	Tuberculosis		F		
Do you smoke? How much? Do you drink alcoholic beverages? If yes, how much daily/weekly Female History: (for ultrasound purposes) Last monthly period Could you be pregnant? Yes No Additional information you may feel significant: With Whom do you live? Alone Spouse Child Other	Kidney (Renal) Disease				
Do you drink alcoholic beverages? If yes, how much daily/weekly Could you be pregnant? Yes No Female History: (for ultrasound purposes) Last monthly period Could you be pregnant? Yes No Additional information you may feel significant: Other With Whom do you live? Alone Spouse Child Other	ls there a history of any of the	above diseases	s in your family? _	If so, which or	nes?
Do you drink alcoholic beverages? If yes, how much daily/weekly Could you be pregnant? Yes No Female History: (for ultrasound purposes) Last monthly period Could you be pregnant? Yes No Additional information you may feel significant: Other With Whom do you live? Alone Spouse Child Other	Do you smoke? Ho	w much?	All		
Female History: (for ultrasound purposes) Last monthly period Could you be pregnant? Yes No Additional information you may feel significant: Other With Whom do you live? Alone Spouse Child Other	Do you drink alcoholic bevera	ages?	If yes, how muc	ch daily/weekly.	
Additional information you may feel significant: Child Other					
Do you use an assistive device? Cane Walker Wheelchair Other	With Whom do you live?	Alone	Spouse	Child	Other
	Do you use an assistive devid	ce? Cane	Walker	Wheelchair	Other