Medical History Information

Last Name:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
First Name:	Middle:			Single / Mar / Div / Sep / Widow
Email:		Birth date:	Age:	Sex:
Address:	City:	State:		
ZIP Code:	Social Security No.:	Home Phone:		
Occupation:	Employer:	Employer phone:		

Medical Care Information:

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Do You Have a Family Chiropractor?: ☐ No ☐ Yes, Name of Chiropractor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Have you ever had any surgeries: ☐ Yes ☐ No If yes, Last Surgery Date:			
Reason for Surgery:			

Present illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐ Pace Maker
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	
Other:					

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	☐ Ulcer
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Polio
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Scoliosis
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Diverticulitis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	
Other:					

Type of Cancer:	☐ Breast ☐ Lung ☐ Other:
Social History:	

Alcohol? ☐ No ☐ Yes Drinks per week? ____	Caffeine? ☐ No ☐ Yes Drinks per day? ____	Exercise? ☐ No ☐ Yes Hours per week?____ (circle one) Light / Moderate / Strenuous
Misc.:		

Smoking:	Cigarettes? ☐ No ☐ Yes Packs per day?
❑ Current every day smoker ❑ Current some day smoker ❑ Former smoker ❑ Never a smoker	

Medication Allergies:					
☐ ACE Inhibitors	☐ Cephalosporin's	☐ HMG-COA Reductase Inhibitors	☐ Macrolides	☐ Paxil	☐Sertraline Derivatives
☐ Amoxicillin	☐ Cipro	☐ Ibuprofen	☐ Mepridine	☐ Penicillin	☐ Sulfa
☐ Aspirin	☐ Codeine	☐ Iodine	☐ Metronidazole	☐ Percocet	☐ Tetracycline
☐ Bactrim	☐ Darvon	☐ Keflex	☐ Morphine	☐ Pravachol	☐ Ultram
☐ Benadryl	☐ Demerol	☐ Levaquin	☐ NSAIDS	☐ Propoxyphene	☐ Zestril
☐ Biaxin	☐Erythromycin	☐ Lipitor	☐ Opioid Analgesics	☐ Quinolones	☐ Zocor
☐ Cefaclor	☐Flagyl	☐Lisinopril	☐ Peroxitine Derivatives	☐ Salicylates	☐ Zoloft
Other: What are the reactions you face? (Example: Hives, Rash, etc.)					

Medications:	If you have more than 7 medications, please let us know so that we may add the additional meds.				
Medication Name	**Dose**	**Form**	**Route**	**Frequency**	**Date Started**
(Example: Zyrtec)	10 mg	Tablet	By mouth	once per day	10/24/2008
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Race: ❑ White ❑ African American ❑ Asian ❑ Am Indian or AK Native
❑ Native Hawaiian or other Pacific Islander ❑ Decline

Ethnicity: ❑ Non-Hispanic or Latino ❑ Hispanic or Latino ❑ Decline

Preferred Language: ❑ English ❑ Spanish ❑ Portuguese ❑ Italian ❑ French
❑ Chinese ❑ Russian ❑ Japanese

Preferred Contact: ❑ Phone ❑ Email ❑ Text ❑ Fax ❑ Postal Mail ❑ Other: _____

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.