Name: _____ Age: _____ Occupation: _____

Date of Injury: _____ Date of Surgery (if applicable): _____ Date of last physical: _____

Medical History: (check all that apply and circle if multiple options per line)

□ Cancer *type* _____
□ Diabetes *type* _____
□ High Blood Pressure
□ Heart Disease
□ Heart Attack
□ Angina/Chest Pain
□ Stroke/TIA
□ Bleeding Disorder
□ Osteoarthritis
□ Osteoporosis
□ Rheumatoid Arthritis
□ Autoimmune Disease
□ Hyper/Hypothyroidism
□ HIV, HEP B, HEP C
□ Tuberculosis
□ Anemia
□ Frequent/Severe Headaches
□ Blood Clot
□ Seizures/Epilepsy
□ Kidney Disease
□ GERD/Ulcers
□ Emphysema/COPD
□ Multiple Sclerosis/Parkinson's
□ Other: _____

In the past year have you had:

□ Falls *how many* _____
□ Dizziness/Fainting
□ Nausea/Vomiting
□ Urinary/Fecal Leakage
□ Urinary Fecal Urgency
□ Other change to Bowel/Bladder function
□ Unexplained Weight Change
□ Difficulty sleeping
□ Menstrual Irregularities
□ Fever/Chills/Sweats
□ Difficulty swallowing
□ Double vision
□ Pain with sexual activity
□ Numbness/Tingling *where* _____
□ A motor vehicle/workplace accident

Are you pregnant? Yes / No

Do you drink alcohol? Yes/No If yes, how many drinks per week: _____

Do you or have you ever smoked or used tobacco products? Yes/No

If yes do you smoke cigarettes, vape, chew or other? _____

How many _____ packs x _____ years. Date of last tobacco use. _____

Have you had any recent x-rays, MRI, CT, Nerve Conduction Studies? If so what did they show?

_____

_____

Please list any surgeries with dates of surgery if possible:

_____

_____

_____