



MEDICAL HISTORY FORM

Name: _____

DOB: _____

Date of last physical: _____

Please check the following: YES NO Medications/Side Effects

Allergies	_____	_____	_____
Anemia	_____	_____	_____
Aneurysm	_____	_____	_____
Arthritis (type)	_____	_____	_____
Rheumatoid	_____	_____	_____
Osteoarthritis	_____	_____	_____
Bowel/Bladder Problems	_____	_____	_____
Diabetes	_____	_____	Insulin Dependent? _____
Dizziness or Fainting	_____	_____	_____
Emphysema/Asthma	_____	_____	_____
Epilepsy/Seizures	_____	_____	_____
Gastritis/Ulcers	_____	_____	_____
Gout	_____	_____	_____
Headaches	_____	_____	_____
Head Injuries	_____	_____	When? _____
Hearing/Vision Difficulties	_____	_____	_____
Heart Disease/Attack	_____	_____	When? _____
Hemophilia	_____	_____	_____
Hernia	_____	_____	_____
High/Low Blood Pressure	_____	_____	_____
Irregular Heart Rate	_____	_____	_____
Lyme Disease	_____	_____	_____
Osteoporosis	_____	_____	_____
Pacemaker	_____	_____	_____
Shortness of Breath	_____	_____	_____
Sleeping Problems	_____	_____	_____
Spine Injuries	_____	_____	When? _____
Stroke or TIA	_____	_____	_____
Thyroid Trouble	_____	_____	_____
Vascular Problems	_____	_____	_____
Weight/Energy Loss	_____	_____	_____

Salem Sports & Spine, PC

Continuation of Medical History

Fractures/ Broken Bones: _____

Surgeries:

_____ Year _____

_____ Year _____

_____ Year _____

_____ Year _____

Pain Medications: _____

(please list quantity)

Patient/Guardian Signature _____ Date _____

Print Name _____