



Patient Medical Profile

Patient Name : _____ Age: _____

Date of Injury: _____ Date of Birth: _____

Who may we thank for referring you to us? _____

Primary care physician (if different): _____

Other providers you want to receive your records: _____

CURRENT HEALTH

Please list any medical problems you have or have ever been given the diagnosis:

- Heart disease or attack
- Diabetes
- High blood pressure
- High cholesterol
- Asthma
- COPD / Emphysema

- Stroke
- Cancer
- Thyroid problems
- Kidney disease
- DVT (Blood clot)
- Chronic headaches

- Osteoporosis / Low Bone Density
- Stomach ulcers
- Heartburn / Reflux
- Rheumatoid arthritis
- Gout / Pseudogout
- Depression

Height: _____

Weight: _____

Please list other medical problems:

Females Only: Currently Pregnant?

Yes No Possibly

NONE OF THESE APPLY TO ME

SURGICAL HISTORY

Please list all previous surgeries and the approximate year:

I HAVE NOT HAD ANY SURGERIES

Surgery:	Year:	Surgery:	Year:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have allergies to or problems with anesthesia? No Yes Describe: _____

MEDICATIONS

Please list any medication you currently use, including over-the-counter medications, vitamins, and supplements::

I TAKE NO MEDICATION

ALLERGIES

NO KNOWN DRUG ALLERGIES

Penicillin

Iodine

Latex

Sulfa Drugs

Diagnostic Dyes

Adhesive Tape

Other: _____

SOCIAL HISTORY

Current / Past Occupation: _____ I am Disabled Reason: _____

Who lives with you? _____ I live alone

Do you drink alcohol? No Yes How Often? Daily Weekly Monthly Infrequently

Do you smoke? No I quit in _____ (year) Yes Number of packs daily: _____

Do you use any other substances? Smokeless tobacco Recreational drugs Please list: _____

