MEDICAL HISTORY FORM

Name: _____ Today's Date: _____

Date of Birth: _____

Height: _____ feet _____ inches

Weight: _____ lbs.

Recent changes in weight? Y / N

Increase/Decrease

How much? _____ lbs.

Please check all that apply:

□ Your injury is a result of an accident from employment.

□ Your injury is a result of an auto accident.

□ Your injury is a result of any other type of accident.

Have you had any surgeries or do you have any surgeries scheduled? Y / N

Injury/ Surgery Date: _____/_____/_____ Injury/ Surgery Date: _____/_____/_____

Please explain how the injury occurred _____

_____

_____

_____

How is your general health? Poor Fair Good Excellent

Please circle your activity level: Low Medium Active Highly Active

Have you had or do you have any of the following:

__Heart Problems __Hepatitis A or B __Vision Problems __Pacemaker/Defibrillator
__Hypertension __Hepatitis C __Parkinson Disease __Seizure Disorder
__Vascular Disease __HIV Positive __Alzheimer Disease __Hearing Loss
__Stroke __Rheumatoid Arthritis __Psychiatric Problems __Currently Pregnant
__Diabetes __Obesity __Alcoholism __MRSA
__Kidney Disease __Osteoarthritis __Known Allergies: (latex/ polypropylene/ plastic/ silicone)
__Osteoporosis __Pulmonary Disease (TB) __ Amputation