Medical History

Date:_____

Name:_____ **Date of Birth:**_____

Hand Dominance: ___Right ___Left ___Ambidextrous **Height:**_____ **Weight:**_____

Primary Care Doctor:_____ **Referring Doctor:**_____

Chief Complaint for today's visit:_____

Is your problem the result of an injury? ____ No Injury ____ Injury ____ Injury at Work ____ Sport Injury

____ Auto Accident ____ Prior Surgery **Date of Onset:** (mm/dd/yyyy) _____

How long have the symptoms been present: (ex. 2 days, 4 months) _____

Race: ___African American ___Asian ___Caucasian ___Native American ___Pacific Islander ___Other ___Decline to Answer

Ethnicity: ___Hispanic ___Non-Hispanic ___Other ___Decline to Answer **Preferred Language:**_____

Drug Allergies:_____

Are you allergic to? ____Latex ____Iodine ____Tape **Metal Allergy:**_____

Present Medications (attach list if needed)	**Medical Problems** (i.e…diabetes, hypertension,etc..)	**Previous Surgeries** (list procedure and year)

Do you take any type of Blood Thinner? _____Yes _____No

Do you use tobacco products?	_____Yes	_____No	_____#packs/day
Do you drink alcohol?	_____Yes	_____No	_____#/week
Are you pregnant?	_____Yes	_____No	
Are you Claustrophobic?	_____Yes	_____No	

Please list any Mechanical/Magnetic/Electrical Implants:_____

Marital Status: ____Single ____Married ____Divorced ____Separated ____Widowed

Number of Children:_____ **Occupation:**_____

Family History:

High Blood Pressure	_____Yes	_____No	Cancer	_____Yes	_____No
Heart Disease	_____Yes	_____No	Diabetes	_____Yes	_____No
Anesthetic Complications	_____Yes	_____No	Other_____		

Have you ever had or experienced or are currently experiencing: (Check all that apply)

_____ Vision/Eye Problems	_____ Pneumonia	_____ **Cardiac Pacemaker**
_____ Skin Rash	_____ Heart Attack	_____ **Cardiac Defibrillator**
_____ Migraine Headaches	_____ High Blood Pressure	_____ Kidney Stones
_____ Hearing Loss	_____ Diabetes	_____ Blood in Urine
_____ Epilepsy	_____ Stroke	_____ Numbness
_____ Irregular Heart Beat	_____ Weight Loss	_____ Cancer
_____ Dizziness	_____ Swelling of Feet or Ankles	_____ Anxiety
_____ Shortness of Breath	_____ Blood Stool	_____ Depression
_____ Blood Clots in Legs	_____ Gout	_____ Bleeding Disorder
_____ Wheezing	_____ Vomiting of Blood	_____ AIDS
_____ Tuberculosis	_____ Thyroid Disease	_____ Arthritis

Physician Signature:_____ **Date:**_____