



Health History

FAMILY:

Have your biological parents, siblings or children had any of the following?

- Cancer – type: _____
- Diabetes
- Stroke
- Neurological Conditions (ex. M.S.)
- Heart Attack
- Hypertension
- Arthritis

PAST TRAUMAS:

- Have you had any car accidents? Y N When? _____
- Have you had any broken bones? Y N When? _____ Which? _____
- Have you had any concussions? Y N When? _____
- Have you had any dislocations? Y N When? _____ Where? _____

SIGNIFICANT PAST ILLNESS:

Please list any other significant illnesses you have had as an adult or child.

Illness	Years old	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST SURGERIES:

Please list in chronological order any surgeries you have had.

Type	Year/Age	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREVIOUS TESTS:

Have you had any of the following tests?

	Year	Comments
<input type="checkbox"/> Spinal X-rays	_____	_____
<input type="checkbox"/> CT Scans	_____	_____
<input type="checkbox"/> MRIs	_____	_____
<input type="checkbox"/> Nerve Tests (EMG)	_____	_____
<input type="checkbox"/> Bone Density	_____	_____