Health History

FAMILY:

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

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

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
☐ Spinal X-rays	_________	_______________________________
☐ CT Scans	_________	_______________________________
☐ MRIs	_________	_______________________________
☐ Nerve Tests (EMG)	_________	_______________________________
☐ Bone Density	_________	_______________________________