

Medical History

Patient:

Today's Date:

General Information

1. Is this injury related to? Work Car Accident Other Liability/Potential Lawsuit Not Applicable

2. Do you have a Primary Care Physician / Family Doctor? No Yes

If yes, have you had an appointment with him / her in the last 12 months? No Yes

3. Race/Ethnicity (Please select one):

- | | | |
|--|--|--|
| <input type="checkbox"/> Caucasian (White) | <input type="checkbox"/> Hispanic or Latino Origin | <input type="checkbox"/> Eskimo/Inuit |
| <input type="checkbox"/> African American | <input type="checkbox"/> Asian | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Other | <input type="checkbox"/> Declined | |

| Please Mark One Box For Each Item | No | Yes Under a Year | Yes Over a Year | No Answer / Invalid | Please Mark One Box For Each Item | No | Yes Under a Year | Yes Over a Year | No Answer / Invalid |
|---------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Smoking (including smokeless tobacco) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexual dysfunction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bladder / bowel problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Groin numbness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Psychological condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood clot / DVT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness / faintness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Breathing difficulties / asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergy to latex (gloves) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty swallowing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other allergy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Circulation / vascular problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Head injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Peripheral neuropathy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Obesity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Unexplained weight loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic pain / fibro / headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Double vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fractures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweats / night pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Infection | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Metal Implants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fever / nausea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | No | Yes | If yes, please specify the condition |
|---|--------------------------|--------------------------|--|
| Infection Disease | <input type="checkbox"/> | <input type="checkbox"/> | |
| Neurologic Condition (MS / Parkinson's) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Pediatric Developmental Condition | <input type="checkbox"/> | <input type="checkbox"/> | |
| Skin Disease | <input type="checkbox"/> | <input type="checkbox"/> | |
| Spinal Cord Injury | <input type="checkbox"/> | <input type="checkbox"/> | |
| Degenerative Joint Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Spine <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Lower Extremity |