COLLYARD Chiropractic

Date: _____

PATIENT MEDICAL HISTORY

Patient Name: _____ **DOB:** _____**Height:** _____ **Weight:** _____

Patient Medical History (Check all that Apply)**:** **E-Mail:** _____

Tobacco Use: ☐ Current ☐ Former ☐ Never

Head
☐Trauma

Ears
☐Hearing Aids

Nose/Sinuses
☐Allergic rhinitis
☐Sinus infection

Cardiovascular
☐Aneurysm
☐Angina
☐DVT
☐Dysrhythmia
☐HTN
☐Murmur
☐Mydocardial infraction

Respiratory
☐Asthma
☐Bronchitis
☐COPD - Bronchitis/Emphysema
☐Pleuritis
☐Pnuemonia

Gastroinestinal
☐Cirrhosis
☐GERD
☐Gallbladder disease
☐Heartburn
☐Hepatitis
☐Hiatal hernia
☐Jaundice
☐Ulcer

Genitourinary
☐Hernia
☐Incontinence
☐Nephrolithiasis
☐UTI(s)

Musculoskeletal
☐Arthritis
☐Gout
☐M/S injury

Neurological
☐Epilepsy
☐Seizures
☐Severe headaches/migraines
☐Stroke
☐TIA

Psychiatric
☐Bipolar disorder
☐Depression
☐Anxiety

Endochrine
☐Goiter
☐Hyperlipidemia
☐Hypothyroidism
☐Thyroid disease
☐Thyroiditis
☐Type I DM
☐Type II DM

Heme/One
☐Anemia
☐Cancer

Infectious
☐HIV
☐Tuberculosis (dz)
☐Tuberculosis (exposure)
☐Other: _____
_____
_____
_____

List Current Medications, Dosage and Use (We can also take a copy of your med list)**:**

_____
_____
_____
_____

Patient Allergies and Reactions (Please List)**:**

_____
_____

Patient Surgeries and Hospitalization (Please List)**:**

_____
_____

To the Best of my knowledge, the questions on this form have been accurately answered. I Understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the chiropractic office of any changes in medical statues.

_____ _____

Patient Signature Date