

UPDATED MEDICAL HISTORY

Patient Name: _____ Date: _____

Height _____ Weight _____ BMI: _____

Who is your Primary Care Physician? _____

List Medical Problems You Have or Had:

List All Medications You Take

List Surgeries You Have Had

List Allergies to Medications

Can you take Anti-inflammatory Drugs?

List Any Medical Problems in Your Family

What Hobbies Do You Have? _____

Do You Play Any Sports Regularly? _____

Do You Exercise? _____

Please Mark the Appropriate Answer:

Yes No

- Weight loss or Gain
- Wound healing problems
- Psoriasis
- Depression
- Blood clots
- Bleeding Problems
- Heart attack
- High blood pressure
- Stroke
- Sciatica
- Diabetes
- Cancer
- Drink Alcohol
- Use Recreational Drugs

Yes No

- Asthma
- Pneumonia
- Stomach Ulcers
- Acid Reflux
- Prostate problems
- Urinary infections
- Fibromyalgia
- Gout
- Hepatitis
- AIDS
- Osteoporosis
- Taken Prednisone
- Regular tobacco Use

SIGNATURE: _____ Date: _____