P: (630) 434-0271
Toll Free: (800) 974-4DPT
F: (630) 515-1536

Patient Medical History Form

Name: ____________________ **DOB:** ____________________

Home Phone: ____________________ **Work Phone:** ____________________

Occupation: ____________________ **Leisure Activity:** ____________________

Please Check The Following Conditions As They Apply To You:

Condition	Yes	No	Explanation
Latex Allergy			
Other Allergies			
Heart Disease			
High Blood Pressure			
Diabetes			
TB			
Hepatitis			
Rheumatoid Arthritis			
Cancer			
Pacemaker			
Stroke			
Severe Dizziness			
Kidney Disorders			
Blood Disorders			
Thyroid Disease			
Other Autoimmune Illness			

1. What brings you here today? ____________________

2. When did you first experience this problem? ____________________

3. Have you been previously treated for this? ____________________

4. What makes the problem better or worse? ____________________

5. Are you currently taking any medication: YES NO
   If yes please list: ____________________

6. Have you had any past or present surgical procedures? YES NO
   If yes please list: ____________________

7. Are you currently pregnant? YES NO
   Been pregnant in the last year? YES NO

8. Do you smoke? YES NO Packs per day? ____________________

9. Do you drink alcohol? YES NO How often? ____________________

Signature: ____________________ **Date:** ____________________