Past Medical History

Medical History
Please indicate the conditions you currently have or have had in the past. If No Known Medical History - please indicate here □

- ADHD
- Alzheimer’s Disease
- Amputation
- Aneurysm
- Atrial Fibrillation
- Asthma
- Autism
- Blood/Clothing Disorder
- Brain Tumor
- Cancer
- ADHD
- Cerebral Palsy
- Hyperlipidemia
- Peripheral Artery Disease
- Chronic Pain
- Congestive Heart Failure
- Kidney Disorder
- Liver Disease
- Coronary Artery Disease
- Lung Disease
- Depression
- Diabetes Type I
- Diabetes Type II
- Heart Disease
- Fibromyalgia
- Migraine Headaches
- Multiple Sclerosis
- Osteoarthritis
- Parkinson’s Disease
- Post-Concussion
- Rheumatoid Arthritis
- Seizures/Epilepsy
- Spinal Cord Injury
- Spinal Stenosis
- Stroke
- Traumatic Brain Injury
- Other

Surgical History
Previous operations:

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<th>Type</th>
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- No Surgeries

Family Medical History:
□ Check Box if No Known Family Medical Problems or:

Please indicate if there is a family member with any of the following conditions and their status using the symbols below:

A=Aunt B=Brother C=Cousin D=Daughter F=Father GM=Grandfather M=Mother S=Sister SN=Son U=Uncle

1=Alive 2=Deceased 3=Unknown

- ADHD
- Alzheimer’s Disease
- Amputation
- Aneurysm
- Atrial Fibrillation
- Asthma
- Autism
- Blood/Clothing Disorder
- Cancer
- Hyperlipidemia
- High Blood Pressure
- Kidney Disorder
- Liver Disease
- Lung Disease
- Lupus
- Migraine Headaches
- Multiple Sclerosis
- Osteoarthritis
- Parkinson’s Disease
- Peripheral Artery Disease
- Post-Concussion
- Rheumatoid Arthritis
- Seizures/Epilepsy
- Spinal Cord Injury
- Spinal Stenosis
- Stroke
- Thyroid Disease
- Traumatic Brain Injury
- Other
SOCIAL HISTORY

**Patient Name:**

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### Marital Status:
- ☐ Single
- ☐ Married
- ☐ Significant Other
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Unknown

### Living Status:
- ☐ Alone
- ☐ Spouse
- ☐ Parents
- ☐ Adult Children
- ☐ Significant Other
- ☐ Caregiver
- ☐ Children
- ☐ Other Relative

### Living Arrangements:
- ☐ House
- ☐ Apartment
- ☐ Facility

### Employment:
- ☐ Full-time
- ☐ Homemaker
- ☐ Long term Disability
- ☐ Not Working
- ☐ Part-Time
- ☐ Retired
- ☐ Short-term Disability
- ☐ Student
- ☐ Unemployed

### Occupation:

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### Education:
- ☐ None
- ☐ Grade School
- ☐ High School
- ☐ High School Equivalent (GED)
- ☐ Some College/Tech School
- ☐ College Graduate
- ☐ Grad School/Advanced Degree

### Tobacco Use:
- ☐ Yes _____ Packs/Day
- ☐ No
- ☐ Former Smoker-Stop Date/Year _____

### Alcohol Use:
- ☐ Yes _____ Drinks/Day/Week
- ☐ No

### Do you use any illegal or recreational drugs?
- ☐ Yes _____ Name of drug
- ☐ No

### Do you have any history or prescription drug abuse?
- ☐ Yes _____ Name of drug
- ☐ No

### Medication Allergies and Type of Reaction/s:

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☐ No Known Medication Allergies

### Medications:
Please List Current Prescribed Medications, Supplements, and any Over-the-Counter Medications Below or Attach List-Please Continue on Back of This Page if Needed.

- ☐ No Current Medications

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<th>NAME OF MEDICATION</th>
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<th>HOW OFTEN IS IT TAKEN/PRESCRIBED</th>
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