MED STAR
SPECIALIST CLINIC

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Referring Physician: _____

Are you currently taking any prescription or non-prescription medication? ☐ Yes ☐ No

List medications: _____

_____

Are you allergic to any medications? ☐ Yes ☐ No Latex allergy? ☐ Yes ☐ No

List medications: _____

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

	Yes	No		Yes	No
Chiropractor	☐	☐	CT Scan	☐	☐
EMG/NCV	☐	☐	General Practitioner	☐	☐
Massage Therapy	☐	☐	MRI	☐	☐
Myelogram	☐	☐	Neurologist	☐	☐
Occupational Therapy	☐	☐	Orthopedist	☐	☐
Physical Therapy	☐	☐	Podiatrist	☐	☐
Emergency Room	☐	☐	X-Ray	☐	☐

Other: _____

Have you ever had ANY of the following?

	Yes	No		Yes	No
Asthma, bronchitis, or emphysema	☐	☐	Severe/frequent headaches	☐	☐
Shortness of breath/chest pain	☐	☐	Vision or hearing difficulties	☐	☐
Coronary heart disease or angina	☐	☐	Numbness or Tingling	☐	☐
Do you have a pacemaker	☐	☐	Dizziness of Fainting	☐	☐
High blood pressure	☐	☐	Bowel or Bladder Problems	☐	☐
Heart Attack or Heart Surgery	☐	☐	Weakness	☐	☐
Stroke/TIA	☐	☐	Weight loss/energy loss	☐	☐
Blood Clot/Emboli	☐	☐	Hernia	☐	☐
Epilepsy/seizures	☐	☐	Varicose veins	☐	☐
Thyroid Disease or goiter	☐	☐	Any pins or metal implants	☐	☐
Anemia	☐	☐	Joint replacement surgery	☐	☐
Infectious Diseases	☐	☐	Neck injury/surgery	☐	☐
Diabetes	☐	☐	Shoulder injury/surgery	☐	☐
Cancer or chemotherapy/radiation	☐	☐	Elbow/hand injury/surgery	☐	☐
Arthritis	☐	☐	Back injury/surgery	☐	☐
Osteoporosis	☐	☐	Knee injury/surgery	☐	☐
Gout	☐	☐	Leg/ankle/foot injury/surgery	☐	☐
Sleeping problems/difficulties	☐	☐	Are you pregnant?	☐	☐
Emotional/psychological problems	☐	☐	Do you use tobacco?	☐	☐

Patient/Guardian Signature Date