

MORRIS FAMILY CHIROPRACTIC

MEDICAL HISTORY

Please thoroughly complete this information sheet about your current and past medical history. PLEASE SIGN AT THE BOTTOM.

Medical Problems Past/Present: (circle)

- Heart Disease/Attack High Blood Pressure
Atrial Fibrillation (A-fib) High Cholesterol
Blood Clots / Vessels Anxiety / Depression
Stroke / TIA Other Mental Health
COPD / Asthma Diabetes Type I or II
GERD/Irritable Bowel Joint Pain / Arthritis
Anemia / Blood Disorder Osteopenia (low bone density)
Tingling / Numbness Degenerative Disc Disease
Headaches / Migraines Scoliosis
Dizziness Eye Problems
Fainting Spells Sinus Problems
Hearing Loss / Tinnitus Thyroid
Seizures / Epilepsy Fibromyalgia
Kidney / Bladder Hepatitis
Autoimmune Disease: Rheumatoid/Lupus/Psoriasis
Cancer (including skin, leukemia, lymphoma)
OTHER Medical Issues:

MEN ONLY: Prostate

WOMEN ONLY: Breast Problems

Menstrual Issues

Are you now or possibly pregnant? Y/N

How many pregnancies? Births?

Pregnancy complications?

Significant Injuries/Traumas including Car Wreck:

Past Surgical History:

- Gall Bladder Appendix Tonsils/Adenoids
Hysterectomy Joint/Bone/Muscle
List others:

FAMILY history of: (circle)

- Heart attack (before 60 years old)
Diabetes
Cancer (not smoking related)
Blood Pressure
High Cholesterol
Rheumatoid Arthritis/Psoriasis/Lupis
Stroke
OTHER:

X-Rays or MRI's: (recent)

DRUG ALLERGIES: NONE or

Category of Rx I am currently taking: NONE or

- Statin (cholesterol) Blood Pressure
Anxiety/Depression Other Mental Health
Diabetes Thyroid Allergies Heart
Headaches Pain/Nerve Pain Antibiotics
Inhaler Eye Digestive Muscle Relaxer
Other:

Vitamins/Supplements and NON Rx:

Work History: Computer/Desk/Office Work

Heavy Lifting/Carrying Long Hours of Driving

Heavy Machinery Repetitive Motion

Sports History:

Military History:

My Primary Care Dr. (PCP) is

Specialists:

Marital Status (circle one): M S D W

Smoking History (circle):

I have never smoked
Current Smoker -- started in (yr)
Vaping Other Tobacco Use Medical Marijuana
Former Smoker
Started in (yr) Stopped in

Alcohol Use: NONE INFREQUENTLY OR

drinks per week for years

Do you drink coffee or any other caffeine?

Name (please print)

Signature

Date: