HISTORY OF INJURY OR ILLNESS

Name: _____ Date: _____

Reason for Appointment: _____

_____

Right or Left: _____ When did it start: _____

Cause of Injury: _____

What makes it better: _____

What makes it worse: _____

What previous treatment have you had: _____

_____

SURGERIES YOU HAVE HAD:

Surgery	Date	Surgeon	Where

CURRENT MEDICATION:

Name	Dose	Reason for Medication

Do you have any allergies to any drugs or foods? Please list all allergies below:

Name	What is the reaction

Do you drink alcohol? _____(if yes, _____ per day / week / month)

Do you smoke? _____(if yes, _____per day / week / month)

Have you had a history of stomach disorders or peptic ulcer disease? _____