PRESENT COMPLAINTS CONTINUED

LIST ANY OPERATIONS THAT YOU HAVE HAD, APPROXIMATE DATE, AND SURGEON:

1. ____________________ DATE ____________ DR. ____________
2. ____________________ DATE ____________ DR. ____________
3. ____________________ DATE ____________ DR. ____________
4. ____________________ DATE ____________ DR. ____________

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ YES PLEASE LIST BELOW ☐ NO

MED ____________________ REACTION ____________________

MED ____________________ REACTION ____________________

MED ____________________ REACTION ____________________

MED ____________________ REACTION ____________________

PLEASE LIST ALL MEDICATIONS / SUPPLEMENTS YOU ARE CURRENTLY TAKING:

MED ____________________ REASON ____________________

MED ____________________ REASON ____________________

MED ____________________ REASON ____________________

MED ____________________ REASON ____________________

DO YOU WEAR ORTHOTICS (shoe inserts)? ☐ YES WHAT TYPE ____________________ ☐ NO

ARE YOU PREGNANT? ☐ YES DUE DATE ____________ ☐ NO

DO YOU SMOKE? ☐ YES AMOUNT PER DAY ____________ ☐ NO
DRINK? ☐ YES ☐ LIGHT ☐ MODERATE ☐ HEAVY ☐ NO
EXERCISE? ☐ YES ☐ SOMETIMES ☐ FREQUENTLY ☐ REGULARLY ☐ NEVER

DOES ANYONE IN YOUR FAMILY HAVE A SIMILAR HEALTH RELATED PROBLEM? ☐ YES ☐ NO

WHO ____________________ WHAT CONDITION ____________________

CARE THEY ARE RECEIVING ____________________

IS IT HELPING? ☐ YES ☐ NO MAY WE CONTACT THEM REGARDING THEIR CONDITION? ☐ YES ☐ NO

PATIENT NAME ____________________ DATE ____________