General Medical History Form

Name: ____ Date: ____________________

Date of Birth: __________ Height: ___________ Weight: ___________ Age: ____________

Family Physician: _________________________ Referring Physician: _____________________

What brings you in our office today? ____

If you had an injury, please explain where you are injured and how the injury occurred:

____

____

Where and when did the injury occur? ____

Do you have a latex allergy? ______Yes ______ No

Do you have a heart condition? ______Yes ______ No

If yes, please explain ____

Do you have asthma? ______Yes ______ No

If yes, do you use an inhaler and how often? ____

Do you have diabetes? ______Yes ______ No

If yes, how long have you known? ____

Do you take insulin? ______Yes ______ No

If yes, how many times a day? ____

Are you on dialysis? ______Yes ______ No

If yes, how many times a week? ____

Do you participate in any special activities or exercise? ______Yes ______ No

If yes, please specify what activities and how many times a week?

____

____

I certify to the accuracy of the medical history provided to the company and authorize the release of any medical information necessary to justify the need for medical equipment.

____

Patient Signature Date