MEDICAL HISTORY

DR. DAN BANGART DR. KEITH BANGART DR. JEFF THOMAS DR. SHANE MOORE DR. RYAN BANGART

PATIENT NAME (LAST, FIRST, MI.): _____

PRESCRIPTION MEDICATIONS:

Medication: _____ Medication: _____

Medication: _____ Medication: _____

Medication: _____ Medication: _____

Medication: _____ Medication: _____

ALLERGIES TO MEDICATIONS:

Medication: _____ Reaction: _____ Medication: _____ Reaction: _____

Medication: _____ Reaction: _____ Medication: _____ Reaction: _____

PREVIOUS SURGERIES: (ADDITIONAL ON BACK)

Type: _____ Year: _____ Type: _____ Year: _____

Type: _____ Year: _____ Type: _____ Year: _____

Type: _____ Year: _____ Type: _____ Year: _____

Type: _____ Year: _____ Type: _____ Year: _____

SELECT ONE:

- Do you have low back pain? ☐ Y ☐ N
- History of drug abuse? ☐ Y ☐ N
- Do you drink alcohol? ☐ Y ☐ N Amount: _____
- Do you smoke? ☐ Y ☐ N Amount: _____ Have you quit? ☐ Y ☐ N
- Are you currently pregnant? ☐ Y ☐ N # of months: _____

MEDICAL PROBLEMS:

Please Check If You Have/Have Had The Following:

☐ Neuropathy
☐ Fibromyalgia
☐ Asthma
☐ Kidney Disease
☐ Hepatitis Select: ☐ A ☐ B ☐ C
☐ Thyroid Problems
☐ Liver Trouble
☐ Aids/HIV
☐ Diabetes /Result Of Last Blood Sugar/HbA1c: _____
☐ Gout
☐ Varicose Veins
☐ COPD
☐ Anemia
☐ Stroke
☐ Bleeding Disorder
☐ Blood Clots
☐ Stomach Problems: Type: _____
☐ High Blood Pressure
☐ Heart Problems Type: _____
☐ Arthritis Select: ☐ Rheumatoid ☐ Osteo
☐ High Cholesterol

Other: _____

FAMILY HISTORY (SELECT ALL THAT APPLY):

☐ Hypertension	☐ Mother	☐ Father	☐ Grandparent	☐ Sibling
☐ Heart Disease	☐ Mother	☐ Father	☐ Grandparent	☐ Sibling
☐ Diabetes	☐ Mother	☐ Father	☐ Grandparent	☐ Sibling
☐ Foot Problems	☐ Mother	☐ Father	☐ Grandparent	☐ Sibling

HEIGHT: _____ **WEIGHT:** _____ **SHOE SIZE:** _____

*I understand that honest and complete answers to each question stated above are important to the provision of my medical care, and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form, I should ask the doctor or member of the medical staff for assistance. This information is true and accurate to my knowledge.

PATIENT SIGNATURE: _____ DATE: _____/_____/_____

(GUARDIAN IF MINOR)