Hinsdale Sport & Spine Therapy, Ltd.

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Medical History Questionnaire and Injury Form

NAME: _____ AGE: _____

SS #: _____OCCUPATION:_____

Date of Injury:_____

How were you injured:_____

_____

_____

LEISURE ACTIVITIES: _____

Have you EVER been diagnosed as having any of the following conditions?

A. Cancer	YES	NO
If YES, describe what kind:_____		
B. Heart problems	YES	NO
C. High blood pressure	YES	NO
D. Asthma	YES	NO
E. Emphysema	YES	NO
F. Chemical dependency (e.g. alcoholism)	YES	NO
G. Thyroid problems	YES	NO
H. Diabetes	YES	NO
I. Multiple sclerosis	YES	NO
J. Rheumatoid arthritis	YES	NO
K. Other arthritic conditions	YES	NO
L. Depression	YES	NO
M. Hepatitis	YES	NO
N. Tuberculosis	YES	NO
O. Stroke	YES	NO
P. Kidney disease	YES	NO
Q. Anemia	YES	NO
R. Epilepsy	YES	NO
S. Other_____		

DATE	Past Surgeries/Significant Injuries
_____	_____
_____	_____

Medications:

_____

_____

Signed:_____Date:_____