



BodyIntel Medical History

Patient Name:	Date:
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Reason for visit: Error! Not a valid bookmark self-reference.

Check which apply to the nature of your visit: <input type="checkbox"/> Athletic/Recreational Injury <input type="checkbox"/> Work related injury	<input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Other:
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Name of physician:

Date of next physician visit:

Have you had diagnostic tests:
 X-ray
 MRI
 Other: _____

Please bring written report of tests if available.

Have you had a related surgery?
 yes (Procedure and Date) _____
 no

Do you have, or have you had any of the following?					
	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Heat/Cold	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergies:	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
High blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Recent Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries:	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Skin Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Urine leakage	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	ringing in your ear	<input type="checkbox"/>	<input type="checkbox"/>
Liver/Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet guidelines	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>

IF YES TO ANY OF THE ABOVE, PLEASE BRIEFLY EXPLAN AND PROVIDE APPROXIMATE DATE (S):

Is there any other information regarding your past medical history that we should know about?

Are you presently taking medication: Yes No **If yes, please list medications and for what condition:**
