MEDICAL HISTORY FORM

Please tell us about your medical team; MD Massage

DC PT Counselor

Primary Reason for seeking care at BritPT:

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Have you EVER been diagnosed as having the following conditions ? Please circle

Yes	No	Cancer	Yes	N	Steroids for more than 6 months in a row?
Yes	No	Heart Problems	Yes	No	Antibiotics for more than 4 weeks ?
Yes	No	Stroke/Aneurism	Yes	No	Have you ever taken blood thinners ?
Yes	No	Blood pressure	Yes	No	Which of the OTC meds have you taken
Yes	No	Circulation issues			in the past week?
Yes	No	Asthma	Yes	No	Aspirin
Yes	No	Bronchitis, Emphyseama	Yes	No	Tylenol
Yes	No	Addictions	Yes	No	Advil/Ibuprofen/ other NSAID
Yes	No	Thyroid Issues	Yes	No	Laxatives
Yes	No	Diabetes	Yes	No	Decongestants
Yes	No	MS	Yes	No	Antihistamines
Yes	No	RA	Yes	No	Antacid
Yes	No	Arthritis	Yes	No	other_____
Yes	No	Depression	Yes	No	sensitive to tape? Latex?
Yes	No	Tuberculosis	Yes	No	Kidney disease
Yes	No	Anemia	Yes	No	Epilepsy
Yes	No	Fibromylagia	Yes	No	Chronic Fatigue Syndrome
Yes	No	Hepatitus			
Yes	No	Other	Yes	No	Supplements_____

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List any accident, injury, broken bones, surgeries, trauma;_____

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