



Primary Elite Chiropractic

1301 Shiloh Rd. NW, Suite #510, Kennesaw, GA 30144 • 678.252.9211
primaryelitechiropractic@gmail.com • www.primaryelitechiropractic.com

Medical History Form

Name: _____ Age: _____ Sex: M F

Family Physician: _____ Phone: _____

Present Weight: _____ Height (no shoes): _____ Desired Weight: _____

Present Status:

- | | | |
|---|-----|----|
| 1. Are you in good health at the present times to the best of your knowledge? | Yes | No |
| 2. Are you under a doctor's care at the present time? | Yes | No |

If yes, for what? _____

- | | | |
|--|-----|----|
| 3. Are you taking any medications at the present time? | Yes | No |
|--|-----|----|

What: _____ Dosages: _____

What: _____ Dosages: _____

- | | | |
|------------------------------------|-----|----|
| 4. Any allergies to medications? | Yes | No |
| 5. History of High Blood Pressure? | Yes | No |
| 6. History of Diabetes? | Yes | No |

At what age: _____

- | | | |
|---|-----|----|
| 7. History of Heart Attack or Chest Pain? | Yes | No |
| 8. History of Swelling Feet? | Yes | No |
| 9. History of Frequent Headaches? | Yes | No |

Migraines? Yes No ; Medications for Headaches: _____

- | | | |
|---|-----|----|
| 10. History of Constipation (difficulty in bowel movements)? | Yes | No |
| 11. History of Glaucoma? | Yes | No |
| 12. Do you have a history of smoking? Yes No ; Currently smoke? | Yes | No |

If so, how many years? _____ How many packs a day? _____

13. Female History:

Pregnancies: Number: _____ Dates: _____

Natural Delivery or C-section (specify): _____

Patient Name:

Patient ID #

Date:

Dr. Signature



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Menstrual: Onset: _____
Duration: _____
Are they regular?: Yes No
Pain associated: Yes No
Last menstrual period: _____

Birth Control Pills: Yes No
Type: _____

Last Check Up: _____

14. Male History:

Date of last Prostate Exam: _____ Physician who performed: _____
Was the Prostate exam normal? Yes No
If no, what was the abnormality and what follow up did you have? _____

(Check all that apply)

____ Low Libido ____ Lack of Energy ____ Decreased Strength
____ Decreased Muscle Mass ____ Sleep Disturbances ____ Hair Loss
____ Poor Memory/Concentration ____ Sadness ____ Decreased Enjoyment of Life

15. Hormone Replacement Therapy: Yes No
What: _____

16. Do you suffer from any of the following? (Check all that apply)

____ Back pain ____ Knee pain ____ Neck pain
____ Hip pain ____ Other pain

17. Past Medical History: (Check all that apply)

____ HIV ____ Kidneys ____ Liver Disease
____ Lung Disease ____ Rheumatic Fever ____ Bleeding Disorder
____ Ulcers ____ Gouty Arthritis (Gout) ____ Thyroid Disease
____ Anemia ____ Heart Valve Disorder ____ Heart Disease
____ Tuberculosis ____ Gallbladder Disorder ____ Psychiatric Illness
____ Drug Abuse ____ Eating Disorder ____ Alcohol Abuse
____ Pneumonia ____ Cancer ____ Blood Transfusion
____ Arthritis ____ Osteoporosis ____ Other: _____

Patient Name:

Patient ID #

Date:

Dr. Signature
