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**

_____

Primary Elite Chiropractic

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

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**

_____