BUSINESS HEALTH PARTNERS

"Partners with Business & Industry"

MEDICAL HISTORY

NAME_____ SS#_____-_____-_____ DATE_____

EMPLOYER_____ JOB_____ DOB_____

Do you have any Medical Illness? List all with date of onset. (Example: High Blood Pressure) ____Yes ____No

_____

_____

_____

Have you ever had any Musculoskeletal problems? (Example: Back,Shoulder, Knees,Etc.) ____Yes ____No

_____

_____

Have you ever had any surgical procedures (If so, list all surgeries with dates) _____Yes _____No

_____

_____

Have you ever had any accidents, broken bones? (If so, explain and put dates) _____Yes _____No

_____

_____

Have you ever had an injury or illness related to your work? (If so, explain and put dates) _____ Yes _____ No

_____

_____

Are you currently taking any medications? (If yes, list below) ____Yes ____No

_____

_____

Do you have any history of significant reactions to medications or food? (If so, explain) _____Yes _____No

_____

_____

I agree that the information given above is complete & accurate. _____

Patient Signature **Date**

Reviewer's Comments:_____

_____

_____

_____ _____

Medical Reviewer **Date**