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 name, dose, and frequency below) ____Yes ____No

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

Do you have a history of smoking? (If so, specify how much, how long, quit date, ect.) _____ Yes _____No

Smoking cessation education provided to patient? _____ Yes _____No _____N/A

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

Patient Signature **Date**

Reviewer's Comments:

________________________________ __________

Medical Reviewer **Date**