

# Medical History Information

Office of James D. Olin, D.C.

<b>Name:</b>			<b>DOB:</b>		
<b>Medical Care Information:</b>					
Do you have a Family Doctor?: Yes No    Name of Doctor:					
City:		State:		Date of last visit:	
Have you seen another Chiropractor recently? Yes No    Name of Chiropractor:					
City:		State:		Date of last visit:	
Have you had any surgeries in the last 5 years: Yes No    If yes, last surgery date:					
Reason for Surgery:					
<b>Present Illness/Conditions:</b> (please circle all that apply)					
AIDS	Cancer	Heart problem	Multiple Sclerosis	Spinal Disc Disease	Epilepsy
Allergies	Cirrhosis/hepatitis	High blood pressure	Pacemaker	Thyroid trouble	
Anemia	Diabetes	HIV/ARC	Prostate trouble	Tuberculosis	
Arthritis	Dislocated joints	Kidney trouble	Rheumatic fever	Ulcer	
Asthma	Diverticulitis	Low blood pressure	Scoliosis	Polio	
Bone fracture	Hay fever	Mental/Emotional difficulty	Sinus trouble	STD's	
Other:					
<b>Family History of Illness:</b>					
AIDS	Cancer	Multiple Sclerosis	Spinal Disc Disease	STD's	Ulcer
Allergies	Bone fracture	Heart problem	Low blood pressure	Sinus trouble	Polio
Anemia	Cirrhosis/hepatitis	HIV/ARC	Mental/Emotional Difficulty	Epilepsy	Scoliosis
Arthritis	Diabetes	High blood pressure	Prostate trouble	Thyroid trouble	Diverticulitis
Asthma	Dislocated joints	Kidney trouble	Rheumatic fever	Tuberculosis	
Other:					
<b>Social History:</b>					
Alcohol? Yes No	Cigarettes? Yes No	Caffeine? Yes No	Exercise? Yes No	hours per week?	
Drinks per week?	Packs per day?	Drinks per day?	(circle one) Light Moderate Strenuous		
<b>Miscellaneous:</b>					
Sports injuries:					
Military injuries:					
Work injuries:					
Head, neck, or back injuries:					
Prior motor vehicle accidents (approximate date(s) and brief description):					

Signature: \_\_\_\_\_ Date: \_\_\_\_\_