Medical History

Please circle to indicate if you have had any of the following:

AIDS/HIV
Allergies to Anesthetics
Allergies to Medicine
Anemia
Angina
Arthritis
Artificial Heart Valves
Artificial Joints
Asthma
Back Problems
Bleeding disorders
Cancer _____
Chemical Dependency
Chest Pain
Chronic Diarrhea
Circulatory Problems
Depression/Anxiety
Diabetes
Ear Problems
Epilepsy
Eye Problems_____
Fainting
Foot or Leg Cramps
Gout
Headaches
Heart Disease
Hemophilia
Hepatitis or Jaundice
High Blood Pressure
High Cholesterol
Kidney Problems
Liver Disease
Low Blood Pressure
Neuritis
Neuropathy
Psychiatric Care
Radiation treatment
Rashes
Reflux GERD
Respiratory Disease
Rheumatic Fever
Shortness of Breath
Sinus Problems
Stroke (year)
Swelling in Ankles, Feet
Swollen Neck Glands
Tuberculosis
Ulcers Stomach
Ulcers Extremities
Varicose Veins
Venereal Disease
Weight Changes

Surgeries you have had:

_____
_____
_____
_____
_____
_____

Medications

_____
_____
_____
_____
_____
_____

Allergies

_____
_____
_____
_____
_____
_____

Chief Complaint

_____
_____
_____
_____
_____
_____
Date of injury
_____
_____

Primary Care Physician

_____
_____

Date last seen

_____

Pharmacy

_____
_____
_____
_____
_____
_____

TREATMENT CONSENT

I hereby consent and give my permission to Doctor Hovancsek (and his Assistants) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Signature of Patient, Parent, Guardian, or Representative Date