L. Robert Gregory, D.C.

Please complete this form before your appointment with the doctor.

Height_____ Weight_____ Sex M / F If female: Pregnant Y / N # of pregnancies____

Surgeries (years)

_____

_____

_____

Complications of surgeries_____

_____

_____

Past Injuries (ex. fractures, dislocations, etc) _____

_____

_____

Current Medical Complaints (diabetes, hypertension, cancer, progressive neurological disorders etc.)_____

_____

Medications/Supplements_____

_____

_____

Allergies_____

_____

Hobbies (ie: gardening, fishing, sports, etc.) _____

_____

If you are employed, please describe the physical nature job_____

_____

Alcohol use Y/N, if so, amount_____ Tobacco Y/N, if so, type and amount_____

Coffee or caffeine Y/N, if so, amount_____ Drug usage Y/N, if so, type and amount_____

Exercise: Rarely _____Daily_____ Other_____

Diet Plan: (Atkins, Jenny Craig, Vegetarian)_____

Parents Health (If deceased, cause of death) _____

_____

Siblings with significant medical problems_____

_____

Circle all that apply to your immediate family (parents, grandparents, siblings)

Diabetes, asthma, high blood pressure, stroke, bleeding disorders,
Heart problems, ear surgeries, early hearing loss, cancer, hay fever.

I certify that this history form is filled out completely and accurately. I have answered all questions truthfully and to the best of my knowledge.

_____

Print Patient Name Date

_____

Signature (Patient/Guardian if under 18) I have reviewed this form with the patient_____ (LRG)