Cobourg Orthopaedic & Sports Injury Clinic

Health History Form

Please check the following conditions that apply to you:

▫ heart disease	▫ drug allergies
▫ lung disease	▫ osteoporosis
▫ high blood pressure	▫ infectious disease
▫ high cholesterol	▫ osteopenia
▫ blood disorders	▫ blood thinners/anti-coagulants
▫ pacemaker	▫ severe headaches
▫ epilepsy	▫ unexplained weight loss
▫ digestive problems	▫ dizziness
▫ arthritis (osteo or rheumatoid)	▫ implants (metal or breast)
▫ skin conditions	▫ asthma
▫ history of throat infections	▫ incontinence
▫ past or present smoker	▫ emphysema
▫ trauma within the past year	▫ gynecological condition/surgery
▫ infection within the past year	▫ cancer (past or present)
▫ surgery within the past year	▫ Hepatitis A,B,C
▫ bowel abnormalities	▫ HIV/AIDS
▫ bladder abnormalities	▫ congenital (born with) abnormalities
▫ current pregnancy	▫ neurological conditions
▫ Diabetes	▫ constipation
▫ concussions	▫ frequent nausea
▫ Multiple Sclerosis	▫ currently taking medication
▫ Parkinson's disease	▫ anxiety disorders
▫ stroke	▫ history of long term steroid usage
▫ memory loss	▫ present treatment by another practitioner
▫ sexual dysfunction	▫ Additional medical conditions:
▫ confusion	_____
▫ balance dysfunction	_____

Please list all medications that you are currently taking:

_____

_____

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