

UPPER CERVICAL CHIROPRACTIC of NEW YORK, PC
DR. GEORGE GERTNER, NUCCA SPECIALIST

Health History

Are you taking any of the following medications?

- NERVE PILLS** **PAIN KILLERS** (incl. aspirin) **MUSCLE RELAXERS** **STIMULANTS**
 BLOOD THINNERS **TRANQUILIZERS** **INSULIN** **OTHER** _____

Have you ever had any of the following diseases or conditions?

- | | | |
|---|---|---|
| <input type="checkbox"/> HEART ATTACK/STROKE | <input type="checkbox"/> HEART SURGERY/PACEMAKER | <input type="checkbox"/> HEART MURMUR |
| <input type="checkbox"/> CONGENITAL HEART DEFECT | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> ARTIFICIAL VALVES |
| <input type="checkbox"/> ALCOHOL/DRUG ABUSE | <input type="checkbox"/> VENEREAL DISEASE | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> SHINGLES | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> FREQUENT NECK PAIN | <input type="checkbox"/> EMPHYSEMA/GLAUCOMA | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> HIGH/LOW BLOOD PRESSURE | <input type="checkbox"/> PSYCHIATRIC PROBLEMS | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> SEVERE/FREQ. HEADACHES | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> ULCERS/COLONITIS |
| <input type="checkbox"/> FAINTING/SEIZURE/EPILEPSY | <input type="checkbox"/> SINUS PROBLEMS | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> DIABETES/TUBERCULOSIS | <input type="checkbox"/> DIFFICULTY BREATHING | <input type="checkbox"/> CHEMOTHERAPY |
| <input type="checkbox"/> LOWER BACK PROBLEMS | <input type="checkbox"/> ARTIFICIAL BONES/JOINTS | <input type="checkbox"/> ARTHRITIS |

Please list any other serious medical conditions that you have or have ever had. _____

Please list anything that you may be allergic to. _____

Please list previous surgeries/treatments with dates. _____

Please list any past serious accidents with dates. _____

Is there anything else about your family health history that you feel is important to share? _____

Do you: Take supplements or vitamins? **YES** **NO** Exercise? **YES** **NO**

Are you on a special diet? **YES** **NO** Since: _____ / _____ / _____

Do you smoke? **YES** **NO** How much? _____ How long? _____

Are you wearing: **HEEL LIFTS** **SOLE LIFTS** **INNER SOLES** **ARCH SUPPORTS?**

What is the age of your mattress? _____ Is it comfortable? **YES** **NO**

For women: Are you taking birth control? **YES** **NO**

Are you pregnant? **YES** **NO** How long? _____ Nursing? **YES** **NO**

Patient Signature _____ **Date** _____