



1000 N Center Street
Ebensburg, PA 15931
814-419-8445

Patient Information

Name: _____

Please answer the following questions:

Height _____ ft. _____ inches Weight _____ lbs.

Smoking Status

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker

Do you have any medication allergies?

- No known medication allergies
- Yes

Please list: _____

Are you currently taking any medications? *If you have a list, we can make a copy.

- Not currently prescribed any medications
- Yes

Please list:

Personal/Family History

DISEASE/CONDITION (Please check all that apply and circle the appropriate answer)

Arthritis	<input type="checkbox"/>	Self	Mother	Father
Osteoarthritis	<input type="checkbox"/>	Self	Mother	Father
Rheumatoid Arthritis	<input type="checkbox"/>	Self	Mother	Father
Fibromyalgia	<input type="checkbox"/>	Self	Mother	Father
Asthma	<input type="checkbox"/>	Self	Mother	Father
Heart Disease	<input type="checkbox"/>	Self	Mother	Father
High Blood Pressure	<input type="checkbox"/>	Self	Mother	Father
Thyroid Disease	<input type="checkbox"/>	Self	Mother	Father
Diabetes	<input type="checkbox"/>	Self	Mother	Father
Kidney Disease	<input type="checkbox"/>	Self	Mother	Father

Autoimmune Type: _____ Self Mother Father

Cancer Type: _____ Self Mother Father

Other: _____ Self Mother Father

WOMEN ONLY:

To the best of my knowledge I am/am NOT pregnant (please circle)

I give my permission/don't give my permission to x-ray me for diagnostic interpretation (please circle)

Please list any major surgeries below:

DATE
