NAME:_____ DATE:_____

EMAIL:_____

D.O.B.:(will be taken on your first visit) AGE: _____

MICHAEL J. MAYNARD, MD
PATIENT HISTORY & PHYSICAL FORM

PLEASE COMPLETE THIS HISTORY FORM, PLEASE DO NOT LEAVE ANY QUESTIONS BLANK, AS YOUR ANSWERS ARE NEEDED IN ORDER TO EVALUATE AND TREAT YOU.

IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO ASK!

PLEASE DESRIBE THE COMPLAINT/INJURY:

_____

_____

_____

YOUR HEIGHT:_____ YOUR WEIGHT:_____

PLEASE LIST **ALL** MEDICATIONS AND VITAMINS/HERBAL SUPPLEMENTS YOU TAKE ON A REGULAR BASIS.
MAKE SURE TO INCLUDE DOSAGES WHENEVER POSSIBLE.

WHAT CURRENT LEISURE ACTIVITIES DO YOU PARTICIPATE IN?
PLEASE CHECK ALL THAT APPLY.

GOLF____ TENNIS_____SWIMMING____BIKING_____HIKING_____

EXERCISE WALKING_____BOATING_____SNOW SKIING_____

GARDENING_____BOWLING_____OTHER_____

DO YOU HAVE A WEEKLY PHYSICAL ACTIVITY/EXERCISE ROUTINE?
IF YES, PLEASE DESCRIBE:

WHAT IS YOUR OCCUPATION? _____