Medical History Form

Name:____

Have you at any time been diagnosed as having any of the following conditions?

___Allergies
___Arthritis
___Bladder problems/ incontinence
___Blood disorders (hemophilia/anemia)
___Bone/joint infections
___Broken bones/fractures
___Cancer (if yes, what kind?__________)
___Circulation/vascular disorders
___Depression
___Developmental or growth problems
___Diabetes or problems with blood sugar
___Fibromyalgia
___Head injury
___Heart problems (including pacemaker)
___High blood pressure/hypertension
___Infectious diseases (TB, hepatitis, HIV)
___Kidney problems
___Liver problems
___Lung problems (including asthma)
___Metal implants
___Neurological problems (stroke, Parkinson's disease, multiple sclerosis, muscular dystrophy, polio)
___Osteoporosis
___Seizures/epilepsy
___Sensitivity to latex rubber
___Skin diseases
___Thyroid problems
___Ulcers/stomach problems

Other: ____

Please list any prescription pills, injections and/ or skin patches you are currently taking.

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Within the past year, have you had any of the following medical tests?

___Angiogram
___Bone Scan
___Biopsy
___Doppler ultrasound
___Echocardiogram
___EKG (electrocardiogram)
___EMG (electromyogram)
___MRI
___Stress test
___X-rays

Patient Signature:____ Date:_____________________