Medical History Form

First Name: Last 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
- Bowel problems/constipation
- Broken bones/fractures
- Cancer (if yes, specify kind)
- Circulation/vascular disorders
- Depression
- Developmental or growth problems
- Diabetes or problems with blood sugar
- Fibromyalgia
- Head injury
- Heart problems (including pacemaker)
- Other:
- 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

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
- Doppler ultrasound
- Echocardiogram
- EKG (electrocardiogram)
- EMG (electromyogram)
- MRI (if yes, results:)
- Stress test
- X-rays (if yes, results:)

Patient Signature: Date: