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
- ☐ 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)
- ☐ High blood pressure/hypertension
- ☐ Other:
- ☐ 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:)

☐ I certify that the above information is complete and accurate.

Date: