

## Medical History Form

Name \_\_\_\_\_

Date \_\_\_\_\_

### Please check any of the following conditions you have or had in the past:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heart disease/Angina          | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Anemia                    |
| <input type="checkbox"/> High blood pressure           | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Diabetes                  |
| <input type="checkbox"/> Blood clot/emboli             | <input type="checkbox"/> Stroke          | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Pacemaker                     | <input type="checkbox"/> COPD            | <input type="checkbox"/> Currently pregnant        |
| <input type="checkbox"/> Kidney disease                | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Epilepsy/Seizure disorder |
| <input type="checkbox"/> Bowel/bladder problem         | <input type="checkbox"/> Allergies       | <input type="checkbox"/> Stroke/TIA                |
| <input type="checkbox"/> Cancer: when _____ type _____ |  | <input type="checkbox"/> Fatigue/energy loss       |
| <input type="checkbox"/> Vertigo/dizziness             | <input type="checkbox"/> Gout            | <input type="checkbox"/> Faintness                 |
| <input type="checkbox"/> Vision or Hearing Difficulty  | <input type="checkbox"/> Smoker          | <input type="checkbox"/> Metal implants            |
| <input type="checkbox"/> Asthma                        |  |  |

### Orthopedic Limitations: (Current)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Osteoporosis    | <input type="checkbox"/> Weakness             | <input type="checkbox"/> Limited range of motion       |
| <input type="checkbox"/> Broken bones    | <input type="checkbox"/> Compression fracture | <input type="checkbox"/> Scoliosis                     |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Sprains/strains               |
| <input type="checkbox"/> Balance/walking | <input type="checkbox"/> Disc problem         | <input type="checkbox"/> joint dislocation/subluxation |

Have you had a recent  X Ray  MRI  CT Scan  EMG  other \_\_\_\_\_

Please list **major** surgeries with dates:

\_\_\_\_\_  
\_\_\_\_\_

Are you currently taking any prescription or non-prescription medications?  yes  no

Please list your medications (will make copy of your list if you prefer):

\_\_\_\_\_  
\_\_\_\_\_

Allergic to medication?  yes  no Please list \_\_\_\_\_

List any other information that would assist in your care. \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Use back of form if need more space, thank you.