PATIENT MEDICAL HISTORY FORM

Name: _____ DOB: _____

MEDICAL HISTORY: Please check any condition you have a history of. Items not checked are understood to be negative.

	Diabetes		Dizziness
	Arthritis		Seizures/Epilepsy
	Osteoporosis		High Blood Pressure
	AutoImmune disorder		Heart Problem
	Thyroid Problem (Hyper or Hypo)		Abnormal Heart Rate
	Recent and sudden Weight Loss/Gain		Pacemaker
	Bowel or Bladder Problems		Defibrillator
	Shortness of breath		Angina (chest pain)
	Asthma		High Cholesterol
	Emphysema		Abnormal Bleeding
	Cancer/ tumors - Where:		
	Other:		

	Fractures Where:
	Back/neck pain When:
	Metal implants Where:
	Exercise regularly How often:
	Allergies Please list:
	Allergic to latex
	Pregnant or suspect pregnancy

SURGERIES: Please list all surgeries, including date

_____

_____

MEDICATIONS: Please check if you are taking any of the following (Please list name of medications)

	Diabetes Medication		Pain Killers
	Heart Medication		Blood Pressure
	Anti-coagulants		Steroids
	Muscle Relaxants		Anti-inflammatory
	Other Medications		

DIAGNOSTIC TESTS: Please check test(s) for **current** problem only.

	X-Ray		CT Scan
	MRI		VNG
	EMG		Bone Density
	Blood Chemistry		Ultrasound
	Other - Please specify:		