MEDICAL HISTORY

PATIENT: _____ AGE: _____

HAVE YOU EVER HAD ANY OPERATIONS? YES NO IF YES, PLEASE LIST AND INCLUDE DATES

DO YOU HAVE, OR HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK BOX AND IF MORE THAN ONE CONDITION IS LISTED ON THE LINE PLEASE CIRCLE THE CONDITION YOU HAVE/ HAD.

HEART DISEASE:	Congestive Heart Failure	[ ]	Valvular Disease	[ ]
	High Blood Pressure	[ ]	Stents	[ ]
	Heart Attack	[ ]	Arrhythmia	[ ]
	Atherosclerotic Disease	[ ]	Coronary Artery Bypass	[ ]
	Angioplasty	[ ]	Angina	[ ]
	Pacemaker	[ ]	Defibrillator	[ ]
LUNG DISEASE:	Chronic Obstructive Pulmonary Disease	[ ]	Asthma	[ ]
	Emphysema	[ ]	Recent PneumonA	[ ]
VASCULAR DISEASE:	Peripheral Arterial Disease	[ ]	Stroke/TIA	[ ]
	Acquired Respiratory Distress Syndrome	[ ]	Chronic Bronchiti	[ ]
	Diabetes I II (please circle)		Hypertension	[ ]
GENERAL MEDICAL CONDITIONS	Arthritis	[ ]	Osteoporosis	[ ]
	Allergies	[ ]	Anxiety or Panic Disorder	[ ]
	Neurological Disease (MS/Parkinsons)	[ ]	Depression	[ ]
	Headaches	[ ]	Previous Accidents	[ ]
	Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)	[ ]	Kidney/Bladder/Prostate or Urination problems	[ ]
	Visual Impairment (such as cataracts, glaucoma, macular degeneration)	[ ]	Incontinence	[ ]
	Back Pain (neck, low back, spinal stenosis degenerative disc disease)	[ ]	Hearing Impairment	[ ]
			Sleep Dysfunction	[ ]
			Cancer	[ ]
	Hepatitis	[ ]	Prosthesis/Implants	[ ]

*ALLERGIES YES NO TO WHAT:
_____

OTHER DISORDERS (please list)
_____

Are you trying to conceive or think you might be pregnant? YES NO

Are you currently taking any medications? YES NO If yes, please list

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IF ANY OF THE ABOVE CHANGES WHILE YOU ARE UNDER OUR CARE, PLEASE NOTIFY US.

PATIENT SIGNATURE:
_____ DATE ___/___/___
(IF PATIENT IS A MINOR, PARENT/LEGAL GUARDIAN MUST SIGN)