

MEDICAL HISTORY

PATIENT NAME: _____ Pt#: _____

Do you now have (or have you had) any of the following? Please circle Yes or No.

High Blood Pressure	Yes	No	Nervous Disorders	Yes	No
Diabetes	Yes	No	Allergies to:		
Heart Attack	Yes	No	Heat	Yes	No
Heart Disease	Yes	No	Ice	Yes	No
Pacemaker	Yes	No	Latex	Yes	No
Headaches	Yes	No	Other	Yes	No
Kidney Problems	Yes	No	Hernia	Yes	No
Seizures	Yes	No	Cancer	Yes	No
Metal Implants	Yes	No	HIV	Yes	No
Surgery	Yes	No	Currently Pregnant	Yes	No
Osteoporosis	Yes	No	Currently Nursing	Yes	No
Stroke	Yes	No			

If you answered "Yes" to any of the questions above, please explain, including dates of illness, condition and/or surgeries: _____

Please list all medications you are currently taking: _____

I certify that the above medical information is correct to the best of my knowledge.

(Signature of Patient and/or Parent if Patient is a Minor) Date: _____