Medical History

Name ______________________________Date of Birth ___________Date___________

Height _____________Current Weight ____________

Medical History (Check all that apply)

☐ Angina	☐ Hepatitis	☐ Migraines/HA	☐ Cancer
☐ Arrhythmia	☐ Head injury	☐ Osteoarthritis	☐ Diabetes
☐ MI/Heart attack	☐ HIV/AIDS	☐ Rheumatoid Arthr	☐ Asthma
☐ Stroke/CVA	☐ Kidney Disease	☐ Osteopenia	☐ Fractures
☐ TIA/mini stroke	☐ Metal Implants	☐ Osteoporosis	☐ Pacemaker
☐ High Cholesterol	☐ Emphysema	☐ Total knee	☐ Vision/Hearing
☐ High Blood Pressure	☐ Chronic Bronchitis	☐ Total Shoulder	☐ Total Hip
☐ Other Heart disease	☐ Epilepsy/Seizures	☐ Pregnant (______/wks)	☐ Spinal Cord injury

Do you have any allergies? Specify:____

Have you had any recent injections? Yes No
If yes, please specify____

Any recent infections? Yes No
If yes, please specify____

Any other medical problems? Yes No
If yes, please specify____

Surgeries/Hospitalizations:

Surgery Type Hospital Dates

1.____
2.____
3.____

Current prescription, over the counter medications and/or nutritional supplements:

Recreational/Leisure activities

____