MEDICAL HISTORY

NAME:______________________________________AGE:__________DOB:_________________

Weight:________Weight: 5yrs. Ago____________Height:___Height: 5yrs. Ago__________

Doctors: Family:____________________________Referring:__________________________________

Others:____

Please check if you have any of the following:

______________Allergies
______________Anemia
______________Arthritis
______________Bone Loss(Osteoporosis, Osteopenia)
______________Cardiac (MI, Arrhythmia, Angina)
______________Cancer
______________Cerebral Palsy
______________COPD
______________CVA (stroke)
______________Diabetes
______________Hearing Loss
______________High Blood Pressure

____________Hypoglycemia
____________Kidney Disease
____________Liver Disease
____________Lupus
____________Multiple Sclerosis
____________Parkinson's
____________Polio
____________Seizure Disorder
____________Thyroid(hyper,hypo)
____________Visual Loss
____________Other_______

Past Surgeries:

	TYPE	DATE
1.	______________________	______________________
2.	______________________	______________________
3.	______________________	______________________

Have you ever broken any bones?:____

Past motor vehicle accidents?:____

Are you taking any medications?:____

Please list:____

Do you have any metal implants?:____

Are you, or do you think you may be, pregnant?: Yes__________ No__________

Do you have children?: Yes_________ No ____________ Ages:____________________

Do you smoke?: Yes________ No_______How long have you smoked?________________

What sports or recreational activities do you participate in?:__________________________

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Briefly describe your present problem:_____________________________________

____

Are you working?: Please circle from the following: Full Time Part Time Retired
Student Not Employed

Occupation:________________________________