Medical History

Patient Name:_____ Date of Birth:_____

Physician Name:_____ Medical Clinic:_____

Are you currently under medical care now Y or N Describe:_____

List of serious operations and illnesses: _____

_____

_____

☐ Diabetes Type _____ ☐ Controlled ☐ Uncontrolled

Cancer _____ ☐ Chemo Therapy ☐ Radiation Location _____

Check (✓) if you have or had any of the following: Explain:

☐ Heart Disease _____
☐ High Blood Pressure _____
☐ Low Blood Pressure _____
☐ AFIB _____
☐ Artificial Heart Valves _____
☐ Pacemaker _____
☐ Defibrillator_____
☐ Angina _____
☐ Liver Disease _____
☐ Hepatitis Type _____
☐ Blood Disorders _____
☐ Clotting Factors _____
☐ Stroke_____
☐ HIV _____
☐ Latex Allergy _____
☐ Metal Allergy _____
☐ Medication Allergy_____
_____
_____

☐ Asthma _____
☐ COPD / Emphysema _____
☐ TB _____
☐ CPAP / Sleep Apnea _____
☐ Kidney Disease _____
☐ Thyroid _____
☐ Steroid Treatment _____
☐ Autoimmune Disorders _____
☐ Treatment for Osteoporosis _____
☐ MS ☐ Parkinsons ☐ Rheumatoid Arthritis_____
☐ Artifical Joints_____
☐ Dementia _____
☐ PTSD / Mental Health_____
☐ Chemical Dependency_____
☐ Tobacco Use _____
☐ Autism Spectrum _____
☐ Downs Syndrome _____
☐ Cognative Disability_____
Women: ☐ Pregnant Due Date_____

List All Medications and All Supplements

_____

_____

_____

Medical Updates

Date	Changes