



Medical History Form

(Please Print Clearly)

Name:	Date:
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Have you EVER been diagnosed as having any of the following conditions?

Yes No Heart Problems	Yes No Epilepsy / Seizures	Yes No Implanted Devices
Yes No High Blood Pressure	Yes No Hearing Loss / Disorder	Yes No Cancer
Yes No Pacemaker	Yes No Eye Disease	Yes No Osteoporosis
Yes No Rheumatoid Arthritis	Yes No Muscular Disease / Disorder	Yes No Depression
Yes No Other Arthritic Condition	Yes No Multiple Sclerosis	Yes No Past Pregnancy
Yes No Stroke	Yes No Tuberculosis	Yes No Currently pregnant
Yes No Lung Disease	Yes No Circulation Problems	Yes No Chemical Dependency
Yes No Asthma	Yes No Hepatitis	Yes No Other:
Yes No Diabetes	Yes No Kidney Disease	

Please list any surgeries or other medical conditions for which you have been treated

Date	Surgery/Injury/Condition	Reason:

List all medications you are currently taking (pills, injections, inhalers, skin patches):

Any additional comments or information you would like us to know:

X _____ DATE

PATIENT/GUARDIAN SIGNATURE