

MEDICAL HISTORY - Existing or relevant previous conditions and approximate date

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Muscular Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Parkinsons |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Smoking
of packs/day ____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Cardiac Conditions | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Covid-19 | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> MRSA | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | |

SURGICAL HISTORY - Please check and list date of surgery

- | | | |
|--|---|--|
| <input type="checkbox"/> Aortic _____ | <input type="checkbox"/> Gastric Bypass _____ | <input type="checkbox"/> Pacemaker _____ |
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Heart surgery _____ | <input type="checkbox"/> Parathyroidectomy _____ |
| <input type="checkbox"/> Bypass _____ | <input type="checkbox"/> Hip replacement _____ | <input type="checkbox"/> Thyroidectomy _____ |
| <input type="checkbox"/> Back surgery _____ | <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> Tonsillectomy _____ |
| <input type="checkbox"/> Breast surgery _____ | <input type="checkbox"/> Knee replacement _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Carpal tunnel _____ | <input type="checkbox"/> Lumpectomy _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cholecystectomy _____ | <input type="checkbox"/> Mastectomy _____ | |
| <input type="checkbox"/> C-Section _____ | | |

CURRENT MEDICATIONS -

- Medication list attached
- Do not take any medication or supplements

Medication Name	Dosage	Frequency - ie daily, twice day, weekly	Route - ie oral, inhaled, injection	Reason for medication

- Additional medication added on the back of this form.