MEDICAL HISTORY

Patient Name _____ **Date**_____

HAVE YOU EVER HAD OR DO YOU NOW HAVE
PLEASE CHECK IF YES

High Cholesterol	Heart Attacks
High/Low Blood Pressure	Heart Disease
Varicose Veins	Chest Pain/Discomfort
Lung Disease	Rheumatic Fever/Heart Murmur
Coughing up Blood	Cancer
Shortness of Breath	Epilepsy
Cough/Sputum	Diabetes
Back Injuries	Gout
Neck Pain	Stroke
Back Pain	Arthritis
Pacemaker	Awaken at Night - Urination
Smoke	
Operations (please list)	Medications (please list) Dosage/Frequency
Orthopedic Problems (please list)	Physical Activities (please list)

PATIENT SIGNATURE _____