



PERSONAL MEDICAL HISTORY

Have you **EVER** had any of the following? Please check the box to the right if yes.

Heart Disease		Arthritis	
High Blood Pressure		Osteoporosis	
Diabetes		Osteopenia	
Heart Attack		Seizures	
COPD/Emphysema		Parkinson's	
Asthma		HIV/ Hepatitis	
Stroke		Pacemaker	
Cancer		Other	

Are you a current smoker: (circle one) **YES / NO**

Please list all surgeries:

Please list any allergies:

Please list medications:

Signature of Patient: _____ **Date:** _____