PERSONAL MEDICAL HISTORY

Have you <u>EVER</u> 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: (Check one) YES☐ or **NO**☐

Please list all surgeries:

_____

_____

_____

Please list any allergies:

_____

_____

_____

Please list medications:

_____

_____

_____

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