

# ADVANTAGE

## Therapy Centers

1998 Route 70 East  
Cherry Hill, NJ 08003  
Tel (856) 424-2000  
Fax (856) 424-2007

100 Kings Way East, Suite B4  
Sewell, NJ 08080  
Tel (856) 256 – 0007  
Fax (856) 256 – 1020

1001 Briggs Rd, Suite 270  
Mt. Laurel, NJ 08054  
Tel (856) 840 – 0700  
Fax (856) 840 – 0767

### Medical History Form

Patient Name: \_\_\_\_\_

Are you currently under the care of a physician?      Yes    or    No  
If yes, please list your physician(s) and their specialty(s)

\_\_\_\_\_

Have you had a serious illness, operation, or been hospitalized in the past 5 years?  
If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Please circle any of the following conditions that apply to you:

Diabetes

High Blood Pressure

Allergies

Low Blood Pressure

Circulatory Problems

Hearing Problems

Pace Maker

Vision Problems

Cancer

Balance Problems

Thyroid Problems

Do you have any disease or problem not listed that you feel that we should know about?  
If yes, please explain:

\_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_

Are you allergic to any medications?    Yes    or    No

\_\_\_\_\_

Are you allergic to tape or latex?      Yes    or    No

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date