ADVANTAGE
Therapy Centers

Medical History Form

Patient Name_____

Are you currently under the care of a physician? Yes 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? Yes No
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
Cardiac Problems	Vision Problems
Pace Maker	Balance Problems

Do you have any disease or problem not listed that you feel that we should know about? Yes No
If yes, please explain_____
_____
_____

Current Medications: _____
_____

Are you allergic to any medications? Yes No
_____
_____

Are you allergic to tape or latex? Yes No

Patient Signature _____Date_____