ADVANTAGE
Therapy Centers

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's signature Date