

## **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 15 yes, please explain:	out?
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	