

## Medical History and Current Health Survey

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

Please read the following list carefully and circle Yes or No as it applies to your medical history and current health. Please include any additional information and conditions for which you are receiving medical care.

<b>Medical History</b>		
Aneurysm	Yes	No
Arthritis (Rheumatoid or Osteoarthritis)	Yes	No
Asthma	Yes	No
Back Pain	Yes	No
High Blood Pressure (Last reading / )	Yes	No
Low Blood Pressure (Last reading / )	Yes	No
Bone Fractures	Yes	No
Cancer (Please provide type and treatment)	Yes	No
High Cholesterol (Last reading / )	Yes	No
Diabetes (Type I or Type II)	Yes	No
Emphysema	Yes	No
Epilepsy	Yes	No
Heart Disease	Yes	No
Family History of Heart Disease (Mother, Father, Siblings)	Yes	No
Hernia	Yes	No
Joint or Ligament Injuries (Please specify)	Yes	No
Muscle Injuries (Please specify)	Yes	No
Neck Pain or Injury	Yes	No
Osteoporosis	Yes	No
Stroke	Yes	No
Surgery	Yes	No

<b>Medical History (continued)</b>		
Terminal Illness	Yes	No
Vertigo or Lightheadedness	Yes	No
Other:	Yes	No
<b>Current Health – Past month</b>		
Back Pain	Yes	No
Chest Pain or Tightness	Yes	No
Discomfort from the Waist Up	Yes	No
Heart Palpitations	Yes	No
Indigestion	Yes	No
Jaw Pain	Yes	No
Joint Pain	Yes	No
Joint Pain	Yes	No
Lightheadedness	Yes	No
Muscle Pain	Yes	No
Nausea	Yes	No
Neck Pain	Yes	No
New Medication or Dosage Changes	Yes	No
Shortness of Breath	Yes	No
Other:	Yes	No

Signature \_\_\_\_\_

Date \_\_\_\_\_