Name:_____ **DOB:** _____ **Today's Date**_____

Medical History

Please Select Any Topics Related to Your Medical History

- ☐ Allergies
- ☐ Angina
- ☐ Bipolar
- ☐ Carpal Tunnel Syndrome
- ☐ COPD
- ☐ Drink Alcohol
- ☐ Epstein-Barr
- ☐ Hearing Difficulties
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Lyme Disease
- ☐ Neurological Issues
- ☐ Pacemaker
- ☐ Rheumatoid Arthritis
- ☐ Sleeping Problems
- ☐ Tobacco Use
- ☐ Vertigo/Balance
- ☐ Women's Health Issue(s)
- ☐ Allergic to Latex
- ☐ Asthma
- ☐ Blood Clot/Emboli
- ☐ Cellulitis
- ☐ Coronary Heart Disease
- ☐ Emphysema
- ☐ Gout
- ☐ Heart Attack
- ☐ Intractable Pain
- ☐ Low Blood Sugar
- ☐ Lymphedema
- ☐ Osteoarthritis
- ☐ Parkinson's Disease
- ☐ Sciatica
- ☐ Spinal Stenosis
- ☐ Torticollis
- ☐ Vision Difficulties
- ☐ Amputation
- ☐ Ataxia
- ☐ Bowel/Bladder Problems
- ☐ Cerebral Palsy
- ☐ Depression
- ☐ Energy Loss
- ☐ Guillain-Barre Syndrome
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Stroke/TIA
- ☐ Varicose Veins
- ☐ Weakness
- ☐ Anemia
- ☐ Bell's Palsy
- ☐ Bronchitis
- ☐ Concussion
- ☐ Dizziness or Faintness
- ☐ Epilepsy/Seizures
- ☐ Headache, Severe
- ☐ Hernia
- ☐ Lipedema
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Oxygen Dependency
- ☐ Pregnancy, Current
- ☐ Sleep Apnea
- ☐ Thyroid
- ☐ Vasculitis
- ☐ Weight Loss

OTHER Important History:_____