Patient Name:

Mark the column labeled “YES” for those conditions you are **CURRENTLY** experiencing:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | YES | Osteoporosis |
| ⃝ | Asthma, Bronchitis, or Emphysema |  | ⃝ | Sleeping Difficulties |
| ⃝ | Shortness of Breath / Chest Pain |  | ⃝ | Bowel or Bladder Problems |
| ⃝ | High Blood Pressure |  | ⃝ | Weight Loss / Gain |
| ⃝ | Epilepsy / Seizures |  | ⃝ | Any Pins or Metal Implants |
| ⃝ | Anemia |  | ⃝ | Emotional / Psychological |
| ⃝ | Diabetes / Type \_\_\_\_\_\_\_\_\_ |  | ⃝ | Pregnant |
| ⃝ | Arthritis / Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | ⃝ | Smoking |
|  |  |  |  |  |
| ⃝ | None of the Above |  |  |  |

Mark the column labeled “YES” for those conditions you have **EVER** had:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| YES |  | Date |  | YES |  | Date |
| ⃝ | Coronary Heart Disease or Angina |  |  | ⃝ | Hernia |  |
| ⃝ | Pacemaker / Defibrillator | \_\_\_\_\_\_\_\_\_\_\_\_ |  | ⃝ | Joint Replacement Surgery | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⃝ | Heart Attack / Heart Surgery | \_\_\_\_\_\_\_\_\_\_\_\_ |  | ⃝ | Ankle / Foot Injury / Surgery | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⃝ | Stroke / TIA | \_\_\_\_\_\_\_\_\_\_\_\_ |  | ⃝ | Neck Injury / Surgery | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⃝ | Blood Clot / Emboli | \_\_\_\_\_\_\_\_\_\_\_\_ |  | ⃝ | Back Injury / Surgery | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⃝ | Infectious Disease | \_\_\_\_\_\_\_\_\_\_\_\_ |  | ⃝ | Shoulder Injury / Surgery | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⃝ | Cancer / Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |  | ⃝ | Knee Injury / Surgery | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⃝ | Gout |  |  | ⃝ | Elbow / Hand Injury / Surgery | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⃝ | Vision or Hearing Difficulties |  |  | ⃝ | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |  |  |  |  |  |  |
| ⃝ | None of the Above |  |  |  |  |  |

**Medications**

Please list any medications you are taking (or provide us with a photocopy), with the dose and frequency.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication Name |  | Dose (i.e. 10 mg) |  | Frequency (i.e. one a day) |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| Please list Vitamins, Supplements, and Over-the-Counter Medicines |
|  |
|  |

Patient/Parent Signature: Date: