



MEDICAL HISTORY

Date:		
Name:		
Are you currently taking any medications? Medication Details :	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you have any allergies to medication or otherwise? List Allergies:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you had surgery in the last year? List type of surgery and details:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you been treated in the Emergency Room in the past 3 months or admitted to the hospital? When? Reason?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Have you ever been diagnosed with any of the following conditions?

Chest Pain	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Diabetes	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Heart attack	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Cancer	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Coughing	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Metal Implants (plates,pins)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Pacemaker	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Epilepsy	YES <input type="checkbox"/>	NO <input type="checkbox"/>
High Blood Pressure	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Shortness of Breath	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are there any other conditions or illnesses that you feel we should know about?				YES <input type="checkbox"/>	NO <input type="checkbox"/>