# Patient Medical History

Patient Name: ____________________________Weight: _________lbs. Height: ___________ Birthdate: ____________

| HEART | NEUROLOGICAL | MUSCULOSKELETAL |
|---|---|---|
| ☐ Heart Attack (MI)/Angina-Date: | ☐ Stroke/TIA/Brain Aneurysm Date: ____________ | ☐ Joint Replacement-Hip, Knee |
| ☐ Coronary Bypass/Stent-Date: | ☐ Migraines/Headaches | ☐ Neck Pain |
| ☐ Pacemaker-Type: ________________ | ☐ Epilepsy/Seizures/Convulsions | ☐ Back Pain |
| ☐ Coronary Heart Disease | ☐ Alzheimer Disease | ☐ Muscular Dystrophy |
| ☐ Congestive Heart Failure | ☐ Parkinson Disease | ☐ Osteoporosis |
| ☐ Mitral Valve Prolapse | ☐ Numbness or tingling in lower legs | ☐ Osteopenia |
| ☐ High Blood Pressure | ☐ Weakness in Legs/Arms | ☐ Arthritis |
| ☐ Low Blood Pressure | ☐ Restless Legs Syndrome | ☐ Fibromyalgia |
| ☐ Heart Murmur | ☐ Chronic Pain Syndrome | ☐ Obesity |
| ☐ Arrhythmia/(A-Fib) | **ENDOCRINE** | ☐ Foot Ulcers/Wounds |
| ☐ On blood thinners Type: _____________________ | ☐ Diabetes-Type I, II | ☐ Edema |
| ☐ Anemia/Bleeding/Clotting Disorder | ☐ Peripheral Neuropathy | ☐ Varicose Veins |
| ☐ Blood Clots/DVT/Pulmonary | ☐ Peripheral Vascular Disease | **EYE** |
| ☐ High Cholesterol | ☐ Kidney Disease/ESRD/Dialysis | ☐ Glaucoma |
| Can you climb a flight of stairs without chest pain, shortness of breath, dizzy, lightheaded? ☐ Yes ☐No | ☐ Liver Disease | ☐ Retinal Detachment |
| | ☐ Thyroid Disease: Hypo/Hyper | ☐Macular Degeneration |
| | ☐ Autoimmune Disease | |
| **LUNG** | ☐ Multiple Sclerosis | **CANCER** |
| | ☐ Lupus Disease | |
| | ☐ Gout | |
| ☐ COPD | **INFECTIOUS DISEASE** | Type: ___________________________ |
| ☐ Asthma/Daily inhalers? ☐ Yes ☐No | ☐ Tuberculosis Date: _________ | Previous Chemotherapy |
| ☐ Emphysema | Treatment Completed: ☐ Yes ☐No Date: _______ | Date of last treatment: __________ |
| ☐ Breathing Problems/Shortness of Breath | ☐ COVID Date: ______________ | Previous Radiation |
| ☐ On Supplemental Oxygen | Fully Vaccinated: ☐ Yes ☐No | Date of last treatment: __________ |
| ☐ Sleep Apnea: Use of C-pap, B-pap, Dental Appliance, Surgical Implant | Boosters: ☐ Yes ☐No | **Psychological** |
| | ☐ MRSA/C-Diff | ☐ Anxiety/Depression |
| | ☐ Hepatitis A, B, C | ☐ Alcoholism/Drug Abuse |

**Smoking Status**: ☐ Never ☐ current smoker/ppd: _________ ☐Former smoker

**Drink alcohol/ETOH use**: ☐ None ☐Social ☐Moderate ☐Heavy

Do you use **cannabis** products? If yes, Type: ____________ How much: ________ How Often: _________

**COMPLETE BOTH SIDES**

**Please List ALL medications including prescriptions, over the counter, blood thinners, and vitamins.** ☐ **NONE**

| Name of Medication | Dose | How Often |
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**Please list ALL allergies including medications, contrast dye, metal, latex, adhesive tapes.** ☐ **No Known Drug Allergies**

| Allergies | Reaction |
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**Please list ALL previous surgeries.** ☐ **NONE**

| Past Surgery | Date |
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The above information is true and correct to the best of my knowledge.

Patient Signature: ___________________________________________________ Date: ___________________________

**COMPLETE BOTH SIDES**