MEDICAL HISTORY

Please check off which medical conditions you either currently have or have had.

O High Blood Pressure

O Heart Attack

O Pacemaker

O Asthma/Bronchitis/Emphysema

O Osteoporosis

O Diabetes

O Arthritis

O Cancer What type? _____

O Neurological Disorders

O Epilepsy/Seizures

O Pregnant

O Chest Pain

O Artificial Bone/Joints

O Stroke/TIA/Blood Clot

O Thyroid

Please list any other medical conditions: _____

_____

Please list any surgeries: _____

_____

Please list any medications: _____

_____