

MEDICAL INFORMATION AND HISTORY

Check the box if you have been diagnosed with any of the following conditions:

Cardiovascular:

Atrial Fibrillation
Blood Clot
Circulation Problem
Edema (Fluid Retention)
Have a Pacemaker?
Heart Attack
Heart Failure
High Blood Pressure
Low Blood Pressure

Neurological:

Alzheimer's Disease
Chronic Migraine Headaches
CVA (Stroke)
Epilepsy / Seizures
Multiple Sclerosis
Muscular Dystrophy
Paralysis
Parkinson's Disease
TIA's (Transient Ischemic Attack)
Traumatic Brain Injury

Musculoskeletal:

Chronic Back / Neck Pain
Dislocated Joint
Fibromyalgia
Fracture
Gout
Lupus
Osteoarthritis
Osteoporosis
Psoriatic Arthritis
Rheumatoid Arthritis

Skin Conditions:

Chronic Wound
Eczema
MRSA
Psoriasis

Respiratory:

Asthma
COPD
Emphysema
Sleep Apnea
Tuberculosis
Valley Fever

Other Conditions:

Diabetes
HIV/AIDS
Hepatitis B or C
Kidney Disease
Liver Disease
Thyroid Disorder
Cancer, if yes give details:

Allergies:

Environmental
Food Related
Lotion or Soap
Plastic or Latex

Other Diagnosis:

Check the box if you are currently having symptoms that are NEW or UNUSUAL for you:

Anxiety / "Nervous"

Feel Dizzy / Light Headed

Severe Cough or Headache

Abdominal Pain

Fever or Chills

Shortness of Breath

Blood in Urine or Stool

Heart Racing / Rapid Pulse

Skin Rash

Chest Pain

Joint or Muscle Swelling

Urinary Incontinence

Depression w/ Suicidal Thoughts

Numbness or Tingling

Weakness

Double Vision or Eye Redness

Open Sore or Wound

Other New Symptom:
