Medical History

Name: _____ DOB: _____ Date: _____

Height:_____ Weight: _____

Are you currently being, or have you ever been, treated for any of the following?

YES	NO	Condition	Explanation
		Allergies (including latex)	
		Asthma	
		Autoimmune Disorders	
		Bleeding Disorders	
		Cancer of any kind	
		COPD	
		Diabetes	
		Defibrillator/Pacemaker	
		Ear/sinus	
		Fainting	
		Gastrointestinal problems	
		Heart Disease	
		High Blood Pressure	
		Kidney Disease	
		Learning Disorders	
		Menstrual Problems	
		Musculoskeletal	
		Osteoporosis/Osteopenia	
		Psychological/psychiatric	
		Seizures	
		Sickle Cell Disease	
		Skin Disorders	
		Sleep Disorders	
		Smoking History (present or past)	
		Stroke/TIA	
		Surgery	
		Thyroid Disease	
		Other	

Please list all medications you are currently taking, including over-the-counter drugs and herbal supplements

Medication	Dosage	Reason

Patient/Guardian Signature: _____