

ADVANTAGE

Therapy Centers

Medical History Form

Patient Name _____

Are you currently under the care of a physician? Yes No

If yes, please list your physician(s) and their specialty(s)

Have you had a serious illness, operation, or been hospitalized in the past 5 years? Yes No

If yes, please describe: _____

Please circle any of the following conditions that apply to you:

Diabetes

High Blood Pressure

Allergies

Low Blood Pressure

Circulatory Problems

Hearing Problems

Cardiac Problems

Vision Problems

Pace Maker

Balance Problems

Do you have any disease or problem not listed that you feel that we should know about? Yes No

If yes, please explain _____

Current Medications: _____

Are you allergic to any medications? Yes No

Are you allergic to tape or latex? Yes No

Patient Signature _____ Date _____