

Patient Name

Date of Birth

Patient ID

Today's Date:

Past Medical History

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Medical History

Check all diseases and conditions that apply.

- | | |
|------------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Accidents/Injuries | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood Clot(s) | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Deep Vein Thrombosis (DVT) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Artificial Joint(s) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Peripheral Arterial Disease (PAD) | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Peripheral Vascular Disease (PVD) | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Venous Insufficiency | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Coronary Artery Disease (CAD) | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Heart Attack (MI) | <input type="checkbox"/> Bipolar |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression |

GERD

Athlete's Foot

Ear/Nose/Throat Issues

Eczema

Glaucoma

Nails

Macular Degeneration

Psoriasis

Gout

Stroke

High Blood Pressure

TIA

HIV or AIDS

Thyroid Disease

Kidney Disease

Endocrine Disorder