

Patient Medical History Form

PATIENT:	DOB:	PHYSICIAN:
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Age: _____ Gender: M / F Height: _____ Weight: _____

1. Have you ever had any serious illnesses, operations, or been hospitalized in the past 5 years? YES / NO

If yes please describe the events with approximate dates: _____

2. Are you now taking any medications including any non-prescription medications? YES / NO

If yes, please list all current medications, dosages, and frequencies: _____

3. Do you have any disease or problem that you feel we should know about? YES / NO

If yes please describe/explain: _____

4. Do you, or have you had any of the following diseases or problems with:

Alcoholism	YES / NO	Depression	YES / NO	Renal Disease	YES / NO
Allergies	YES / NO	Drug Abuse	YES / NO	Respiratory	YES / NO
Anemia	YES / NO	Heart Disease	YES / NO	Seizures	YES / NO
Arthritis	YES / NO	Hypertension	YES / NO	Stroke	YES / NO
Bowel / GI	YES / NO	Pace-Maker	YES / NO	Urinary	YES / NO
Cancer	YES / NO	Immune System	YES / NO	Visual	YES / NO
Circulatory	YES / NO	Liver Disease	YES / NO		
Diabetes	YES / NO	Mental Illness	YES / NO		

If other, please comment below:

Comments: _____

Please read the following:

My signature below certifies that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold the program or any of its staff responsible for any errors or omissions that I have made in the completion of this form.

Patient's signature (or individual completing this form): _____ **Date:** _____

Therapist's signature: _____ **Date:** _____