Medical History

Patient: **Today's Date:**

General Information

1. Race/Ethnicity (Please select one):

☐ Caucasian (White) ☐ Hispanic or Latino Origin ☐ Eskimo/Inuit

☐ African American ☐ Asian ☐ Native American

☐ Other ☐ Declined

Please Mark One Box For Each Item	No	Yes Under a Year	Yes Over a Year	No Answer / Invalid	Please Mark One Box For Each Item	No	Yes Under a Year	Yes Over a Year	No Answer / Invalid
Smoking (including smokeless tobacco)	☐	☐	☐	☐	Sexual dysfunction	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Bladder / bowel problems	☐	☐	☐	☐
Heart condition	☐	☐	☐	☐	Groin numbness	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	Arthritis	☐	☐	☐	☐
Chest pain	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	Psychological condition	☐	☐	☐	☐
Kidney condition	☐	☐	☐	☐	Seizures	☐	☐	☐	☐
Blood clot / DVT	☐	☐	☐	☐	Dizziness / faintness	☐	☐	☐	☐
Breathing difficulties / asthma	☐	☐	☐	☐	Ringing in ears	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Allergy to latex (gloves)	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	Other allergy	☐	☐	☐	☐
Circulation / vascular problems	☐	☐	☐	☐	Head injury	☐	☐	☐	☐
Peripheral neuropathy	☐	☐	☐	☐	Obesity	☐	☐	☐	☐
Unexplained weight loss	☐	☐	☐	☐	Chronic pain / fibro / headaches	☐	☐	☐	☐
Double vision	☐	☐	☐	☐	Fractures	☐	☐	☐	☐
Night sweats / night pain	☐	☐	☐	☐	Infection	☐	☐	☐	☐
Metal Implants	☐	☐	☐	☐	Fever / nausea	☐	☐	☐	☐
Pacemaker	☐	☐	☐	☐	Are you pregnant?	☐	☐	☐	☐

	No	Yes	If yes, please specify the condition
Infection Disease	☐	☐	
Neurologic Condition (MS / Parkinson's)	☐	☐	
Pediatric Developmental Condition	☐	☐	
Skin Disease	☐	☐	
Spinal Cord Injury	☐	☐	
Degenerative Joint Disease	☐	☐	☐ Spine ☐ Upper Extremity ☐ Lower Extremity

Medical History

Patient: **Today's Date:**

Patient Medication List

Please list ALL medications (including prescription, over-the-counter, vitamins, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

Medication	Dosage	Frequency	Route of Administration

☐ **I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE .**

PATIENT SIGNATURE: _____

DATE: _____