PAST MEDICAL HISTORY SURVEY

Patient Name :_______________________________________ DOB:______________

Please check only those that apply.

Asthma ☐ Yes
Arthritis ☐ Yes
COPD ☐ Yes
Heart Attack ☐ Yes
Pacemaker ☐ Yes
Defibrillator Stroke ☐ Yes
Seizures ☐ Yes
Bleeding Problems ☐ Yes
Blood Clot ☐ Yes
High Blood Pressure ☐ Yes
Low Blood Pressure ☐ Yes
High Cholesterol ☐ Yes
HIV ☐ Yes
Aids ☐ Yes
Polio ☐ Yes
Tuberculosis (TB) ☐ Yes
Hepatitis ☐ Yes
Epilepsy ☐ Yes
Diabetes ☐ Yes
Cancer ☐ Yes
Thyroid Problem ☐ Yes
Metal Implants ☐ Yes
Metal Allergies ☐ Yes
Anxiety Disorder ☐ Yes
Bipolar ☐ Yes

Family History:

Is your Father: ☐ Living ☐ Deceased

Has your Father been diagnosed with any of the following:

☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Hypertension ☐ Stroke

Is your Mother: ☐ Living ☐ Deceased

Has your Mother been diagnosed with any of the following:

☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Hypertension ☐ Stroke