

Name: _____ DOB: _____

Date: _____

Have you ever had any of the following: (Please circle all that apply)

- | | | |
|--|------------------------------|----------------|
| Asthma | Diabetes | Osteopenia |
| Atrial Fibrillation | non Insulin dependent__ | Anemia |
| Lupus | Insulin dependent__ | Blood Clots |
| Alzheimer's | Depression | Ulcers |
| Parkinson's | Heart Attack | Reflux |
| Mitral Valve Disease | Osteoporosis | Stroke |
| High Blood Pressure | Cancer | Sleep Apnea |
| Thyroid Dysfunction | Breast | Cataracts |
| MS-Multiple Sclerosis | Prostate | Kidney Stones |
| IBS-Irritable Bowel Syndrome | Skin | Arthritis |
| High Cholesterol | Other_____ | Osteoarthritis |
| CAD-Coronary Artery Disease | Emphysema | Rheumatoid |
| COPD-Chronic Obstructive Pulmonary Disease | Hiatal Hernia | Gout |
| | CHF-congestive heart failure | Seizures |

Have you had a Dexa Scan/Bone Density
No/Yes If yes Year of last scan_____

Do you have a pacemaker? No / Yes

Are you currently under treatment with another physician? No / Yes

If yes for what problem_____

Prior Surgeries Orthopedic / Location and procedure

Date of Surgery

RT / LT _____
RT / LT _____
RT / LT _____
RT / LT _____

Prior Surgeries NON-Orthopedic / Location and procedure

Date of Surgery

Do you have any Metal in your body? NO / YES If yes where located _____

Have you ever been Diagnoses with any of the following: Heart Condition____ Heart attack____ / **If yes what age**____ Stroke____

Stroke____ Abdominal Aortic Aneurysm____ Diabetes____ Blood Disease____ Cancer____ / Location_____

Have you ever had: abnormal ECG/EKG____ Cardiac catheterization/Coronary Angiography____ Angioplasty____

Bypass surgery/CABG____ Cardiac stent____ **If so date**_____ **Any Family history of heart disease__ diabetes__ cancer__**

Name of Cardiologist:_____ **Phone Number** _____

Have you ever had: NO / YES Hepatitis A B C____ HIV/AIDS____ Tuberculosis____

Do you currently have any of the following: NO / YES Chest pain____ Fever____ Infection____

Smoke NO / YES Amount per day_____ **Drink Alcohol NO / YES**

What is your dominant hand? LEFT RIGHT Ambidextrous