

Past Medical History

Please answer only those that apply. Please completely fill in the selected bubbles.

- | | |
|---------------------|---------------------------|
| Asthma | <input type="radio"/> Yes |
| Arthritis | <input type="radio"/> Yes |
| COPD | <input type="radio"/> Yes |
| Heart Attack | <input type="radio"/> Yes |
| Pacemaker | <input type="radio"/> Yes |
| Defibrillator | <input type="radio"/> Yes |
| Stroke | <input type="radio"/> Yes |
| Seizures | <input type="radio"/> Yes |
| Bleeding Problems | <input type="radio"/> Yes |
| Blood Clot | <input type="radio"/> Yes |
| High Blood Pressure | <input type="radio"/> Yes |
| Low Blood Pressure | <input type="radio"/> Yes |
| High Cholesterol | <input type="radio"/> Yes |
| HIV | <input type="radio"/> Yes |
| Aids | <input type="radio"/> Yes |
| Polio | <input type="radio"/> Yes |
| Tuberculosis (TB) | <input type="radio"/> Yes |
| Hepatitis | <input type="radio"/> Yes |
| Epilepsy | <input type="radio"/> Yes |
| Diabetes | <input type="radio"/> Yes |
| Cancer | <input type="radio"/> Yes |
| Thyroid Problem | <input type="radio"/> Yes |
| Metal Implants | <input type="radio"/> Yes |
| Any Metal Allergies | <input type="radio"/> Yes |
| Anxiety Disorder | <input type="radio"/> Yes |
| Bipolar | <input type="radio"/> 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

Patient Name : _____ DOB: _____