IF YOU HAVE A MED LIST WE WOULD BE HAPPY TO PHOTOCOPY IT

Name: _____ **DOB:** _____ **Height:** _____ **Weight:** _____

MEDICAL HISTORY

Do you have or have you ever had any of the following (circle all applicable):

Diabetes	Stroke	High Blood Pressure	Currently Pregnant	Blood Borne Illness
Heart Disease	Parkinsons	Multiple Sclerosis	Seizures	Asthma
Arthritis	Polio	Metal Implants	Heart Attack	Pacemaker
Long Covid	Numbness/Tingling	Cancer	Bipolar Disorder	Depression
Dementia	Joint Replacement	Hypermobility	Immunosuppressed	Auto-Immune Disease

Please list any other pertinent medical information or further explanation on any answered above:

_____

_____

_____

_____

_____

MEDICATIONS

Name	Dosage	Frequency	Administration (oral / injection …)

I attest that the above information is true to the best of my knowledge

Signature: _____ **Date:** _____