

Medical History

Do you have, or have you ever had any of the following?

YES	NO		YES	NO	
		Angina, Chest Pain			Heart Attack
		Irregular Heart Beat			High Blood Pressure
		Heart Disease			Cancer (Type: _____)
		Lung Disease			Asthma or Emphysema
		Hepatitis or Liver Disease			Bleeding Disorder
		Diabetes			Thyroid Disease
		Severe Headaches			Epilepsy, Seizures
		Kidney Disease			Stroke/TIA
		Drug Addiction			Arthritis
		Gout			Ulcer, Acid Reflux Disease
		High Cholesterol			Gastrointestinal Problems
		Skin Problems			Foot and/or Ankle Problems
		Anemia			Depression or Anxiety
		Blood Clots, DVT			Tuberculosis
		Venereal Disease			Other: _____

Does any member of your family have, or has a family member ever had, any of the following?

YES	NO		YES	NO	
		Arthritis			High Blood Pressure
		Muscular Disease			Heart Disease
		Bone or Joint Disease			Cancer
		Bleeding Disorder			Foot and/or Ankle Problems
		Diabetes			Blood Clots, DVT
		Other: _____			