BEYOND WELLNESS

Medical History

Weight: ________ **Height:** ________

Do you smoke? ☐ Y ☐ N ________________ (# packs x # years)

Do you drink? ☐ Y ☐ N ________________ (# drinks per day/week)

Are you pregnant? ☐ Y ☐ N ___/___/______ Due Date

How would you rate your general health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you exercise outside of normal daily activity?
☐ 5+ days/week ☐ 3-4 days/week
☐ 1-2 days/week ☐ Occasionally ☐ None

Have you ever had or been told you have: (MARK ALL THAT APPLY)

Cardiovascular: comment / dates (optional)
- ☐ Heart Disease/Problems ________________
- ☐ Pacemaker ________________
- ☐ Chest pain/Angina ________________
- ☐ Vascular Disease ________________
- ☐ High Blood Pressure ________________
- ☐ High Cholesterol ________________

Musculoskeletal:
- ☐ Fractures/Bone Disease ________________
- ☐ Osteoporosis ________________
- ☐ Joint Replacement ________________
- ☐ Metal Implants ________________
- ☐ Back or Neck Problems ________________
- ☐ Numbness or Tingling ________________
- ☐ Arthritis *Location:* ________________

Neurological:
- ☐ Epilepsy/Seizures ________________
- ☐ Stroke/CVA ________________
- ☐ Headaches/Migraines ________________
- ☐ Dizziness ________________
- ☐ Peripheral Neuropathy ________________

Respiratory:
- ☐ Asthma ________________
- ☐ Shortness of Breath ________________
- ☐ COPD ________________

Gastrointestinal: comment / dates (optional)
- ☐ Hernia ________________
- ☐ Reflux/GERD/Ulcers ________________
- ☐ Bowel/Bladder Problems ________________

Metabolic:
- ☐ Diabetes *Type:* ☐ Pre ☐ I ☐ II
- ☐ Thyroid Disease ________________

Kidney/Liver/Blood:
- ☐ Kidney/Liver Disease ________________
- ☐ Gallbladder problems ________________
- ☐ Hepatitis *Type:* ☐ A ☐ B ☐ C
- ☐ HIV/AIDS ________________
- ☐ Anemia ________________
- ☐ Easy Bruising/Bleeding ________________

Other:
- ☐ Cancer *Location:* ________________
- ☐ Glaucoma/Vision problems ________________
- ☐ Hard of Hearing ________________
- ☐ Skin Condition ________________
- ☐ Depression or Anxiety ________________
- ☐ Other Nervous Problem ________________
- ☐ Unexplained Weight Loss ________________
- ☐ Nausea/Vomiting ________________
- ☐ Fever/Chills/Sweats ________________
- ☐ Excessive Fatigue/Weakness ________________

Please list/describe:

Other Medical Conditions/Diagnoses (not included above): ________________________________

____

Allergies (please include reactions): ________________________________

____

Previous Surgeries (please include date): ________________________________

____

Current Medications: ________________________________
(If Medicare, please provide copy of medication list including dosage, or fill out attached form)

____