



NAME _____

Date of Birth _____

Have you or do you currently have any of the following medical problems?	YES	NO	If yes, please explain
Heart (heart attack, high blood pressure, congestive heart failure, pacemaker, heart surgery, high cholesterol, etc)			
Dermatologic (acne, rosacea, eczema, psoriasis, etc)			
Gastrointestinal (Crohn's disease, colitis, inflammatory bowel disease, GERD, Ulcer)			
Genitourinary (enlarged prostate, endometriosis, ovarian cyst, current pregnancy, etc)			
Ear, Nose, Throat (chronic sinus disease, deafness, tonsillitis, etc)			
Hematologic (sickle cell anemia, Leukemia, Lymphoma, etc)			
Immunologic (Sjögren's syndrome, Rheumatoid arthritis, seasonal allergies, Lupus, Myasthenia gravis, etc)			
Infectious diseases (Hepatitis B, Hepatitis C, HIV, Aids, etc)			
Endocrine (Diabetes- type I or II, hypothyroidism, hyperthyroidism, pituitary tumor, etc)			
Musculoskeletal (osteoarthritis, fibromyalgia, osteoporosis, etc)			
Cancer (skin cancer, bladder cancer, breast cancer, chemotherapy, radiation, etc)			
Neuropsychiatric (cluster headaches, migraine headaches, multiple sclerosis, Alzheimer's, dementia, depression, mood swings, etc)			
Pulmonary (asthma, emphysema, cystic fibrosis, COPD, etc)			

Please explain or list any other medical problems:

Patient Signature: _____ Date: _____

Tech initials: _____

