PAST MEDICAL HISTORY

Please circle any condition that you currently have or have had in the past:

High Blood Pressure	Stroke	Arthritis
Lung Disease/Problems	Cancer	Kidney Disease
Heart Disease/Problems	Diabetes	Liver Disease
Asthma/Allergies	Pacemaker	Angina
Circulation/Bleeding Problems	Osteoporosis	Fibromyalgia

Are you allergic to latex? **YES** **NO**

Do you smoke? **YES** **NO**

Are you pregnant? **YES** **NO**

During the past month, have you often been bothered by feeling down, depressed or hopeless? **YES** **NO**

During the past month, have you often been bothered by little interest or pleasure in doing things? **YES** **NO**

Are you currently taking any medications? **YES** **NO**

If yes, please list ALL medications you are currently taking:

_____

_____

_____

Please list past surgeries and dates:

_____

_____

_____

Please list any medical conditions you have that have not been documented above:

_____

_____

_____

What are your physical therapy and/or fitness goals?

_____

_____

Patient Signature:_____**Date:**_____