MEDICAL HISTORY

Name:	Date of Birth:

Have you been diagnosed with or have a history of any of the following? Please select all that apply.

◯ Acute, undiagnosed pain	◯ Deep vein thrombosis	◯ Liver disease
◯ Allergies	◯ Edema or swelling	◯ Lung disease or infection
◯ Arterial disease	◯ Ehlers Danlos syndromes	◯ Lymphatic disorder
◯ Arthritis	◯ Epilepsy or seizure disorder	◯ Neurological disorder
◯ Autoimmune disease	◯ Fibromyalgia	◯ Numbness or tingling
◯ Bleeding or clotting disorder	◯ Foot pain or disorder	◯ Osteoporosis
◯ Botox or facial fillers	◯ Fracture	◯ Pulmonary embolism
◯ Burn	◯ Head or brain injury	◯ Sprain or strain
◯ Cancer	◯ Headaches or migraines	◯ Stroke
◯ Chronic fatigue or pain	◯ Heart attack or disease	◯ Skin disorder
◯ Concussion	◯ High blood pressure	◯ Thyroid disorder
◯ Covid or long Covid	◯ Joint replacements	◯ Tuberculosis
◯ Diabetes	◯ Kidney disease	◯ Vein disease or infection
◯ Digestive disorder	◯ Lipedema	

Have you had any surgeries or injuries in the past? ◯ Yes ◯ No If yes, please describe.

Have you had any scarring? ◯ Yes ◯ No If yes, please describe.

I use a wheelchair, walker or cane. ◯ Yes ◯ No

Have you had any metal surgically placed in your body (such as after a fracture) or embedded by injury? ◯ Yes ◯ No If yes, please describe.

Have you had any medical implants surgically placed, such as a pacemaker, cochlear implant, glucose monitor, pain pump, port, etc.? ◯ Yes ◯ No If yes, please describe.

Have you had surgical mesh placed in your body after repair of a hernia or prolapse? ◯ Yes ◯ No If yes, please list.

Are you taking any medications currently? ◯ Yes ◯ No If yes, please list.

Do you have a history of chemo or radiation treatments? ◯ Yes ◯ No

Please list any allergies.

Do you have an allergy to aspirin? ◯ Yes ◯ No Do you have an allergy to corn starch? ◯ Yes ◯ No

For females: Are you pregnant or believe you may be pregnant? ◯ Yes ◯ No

By signing this form, I certify that the above information is correct. I certify that I am over the age of 18.

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Signature:	Date: