IN MOTION MEDICAL HISTORY FORM

NAME: ______________________________ DATE: ____________________

To provide you with the highest level of care in the safest and most appropriate fashion possible, we would like you to assist us by filling in the following information. Your medical information is confidential and will be used strictly by following HIPAA guidelines.

PLEASE CHECK THE SPACE IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

High Blood Pressure (Hypertension)	____	**PACEMAKER**	____
Diabetes	____	CVA/Stroke	____
HIV/Hepatitis	____	Heart Attack (MI)	____
Pulmonary Disorder	____	Headaches	____
Organ Transplant	____	Neurological Disorder	____
Joint Replacement	____	Rheumatoid Arthritis	____
Other heart conditions not listed	____	Cancer	____
Current infection	____	Blood Clots (DVT)	____
Recent falls	____	Osteoporosis	____
Recent fracture	____	Seizures	____

Do you smoke? (circle) YES NO   If female, are you currently pregnant? (circle) YES NO

Blood Pressure _____ /_____   Height ______ (in)   Weight ______ (lbs)

Please list any currently prescribed medications, if any:

Please check tests performed for **THIS CONDITION ONLY:** ____ XRAY ____ MRI
____ EMG ____ CT ____ Blood Work ____ Bone Scan ____ Other

CURRENT SYMPTOMS – Please check if you have any of the following symptoms:

Numbness ____   Pins and needles sensation ____   Pain that awakes you ____

Recent unexplained weight loss ____   Current fever ____

SIGNATURE ______________________________   **DATE** ___________