The Senior Alliance

MEDICAL HISTORY

Personal Information
Legal Name:
Date of Birth:
Address:
Phone:

CHECK ALL THAT APPLY:

A History Of:

- ☐ Alcohol use (# of drinks per week) _____
- ☐ Autoimmune diseases
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Blood clots
- ☐ Bronchitis
- ☐ Cancer (type) _____
- ☐ Chronic cough
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse (type) _____
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart attack
- ☐ Hepatitis (type) _____
- ☐ Hernia
- ☐ High Blood Pressure (hypertension)
- ☐ Immuno-compromising condition
- ☐ Lupus
- ☐ Mitral valve prolapse (heart murmur)
- ☐ Osteoporosis or Osteopenia
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Smoking
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Other: _____

Other
Please check all of the following that you have or use:

- ☐ Cane/walker
- ☐ Communication device
- ☐ Contacts
- ☐ Dental Implants
- ☐ Dentures
- ☐ Glasses
- ☐ Hearing aid
- ☐ Metal implants
- ☐ Wheelchair/scooter
- ☐ Oxygen
- ☐ Pacemaker
- ☐ Prosthetics

Other:

- ☐
- ☐
- ☐
- ☐
- ☐