G4athlete

MEDICAL HISTORY

CURRENT or PAST MEDICAL HISTORY OF ANY OF THE FOLLOWING (please circle)

Asthma	Osteoporosis	Spinal Disc Herniation
Heart Condition	Cancer	Chemical Dependency
Blood Clot/Emboli/DVT	Hepatitis	Concussion
Lung Condition	Anxiety	Depression
Hearing Difficulties/Loss	Eating Disorder	Neurologic Deficit
Anemia	Thyroid Condition	Hypoglycemia
Fibromyalgia	Artery Disease	Allergies
Dizziness or Fainting	Sleep Disorders/Insomnia	Varicose Veins
High Blood Pressure	Angina/Chest Pain	Bowel/Bladder Condition
Kidney Condition	Liver Condition	Vestibular Issues
Joint Replacement	Pacemaker	Metal Implant
Seizures/Epilepsy	Rheumatoid Arthritis	Arthritis
Hernia	Multiple Sclerosis	Chronic Pain
Headaches	Stroke	Diabetes
Shortness of Breath	Smoking (past or present)	Infectious Disease
Visual Difficulties	Learning Disability	Emotional Disorder
Joint Sprains	Muscle/Tendon Injury	Fractures/Stress fractures
Spinal Disorder	AIDS	MRSA

Are you currently Pregnant? Yes No **Which Trimester?** 1 2 3

Please list SURGICAL and MEDICAL HISTORY to expand on the above (include dates)

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MEDICATIONS:

Please circle any of the following OVER-THE-COUNTER medications that you are CURRENTLY taking:

Aspirin

Tylenol

Advil/Motrin/Ibuprofen

Herbal Supplements (please specify)

Vitamin Supplements (please specify)

Other (please specify)

Please list all current prescription medications:

_____

_____

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Have you ever had steroid/cortisone injection?	Yes	No
Have you ever had PRP injection?	Yes	No
Have you ever had stem cell injection?	Yes	No
Have you ever had a stress test on a treadmill or ergometer?	Yes	No
Have you previously worn custom or over-the-counter orthotics?	Yes	No
Have you had current imaging (X-ray, CT scans, MRI)? (Please list any dates for imaging)	Yes	No

_____

_____

Do you have any condition that a doctor says may limit your exercise?	Yes	No

_____

Please provide us with any other medical history that you think will help us improve your care.

_____

_____

Signature of Patient_____