

MED WAVE

Name _____
Birth date ____/____/____ Male____ Female____
Home Address _____
City_____ State_____ Zip Code _____
Home Phone_____ Cell Phone _____
Email _____ OK to send emails? Y N

How did you hear about us? _____

Medical Provider's name _____

List all medications you are currently taking _____

Have you ever had any of the following diseases/medical condition(s)?

Y N Heart Attack/Stroke	Y N Psychiatric Problems
Y N Congenital Heart Disease	Y N Kidney Problems
Y N Alcohol/ Drug Abuse	Y N Sinus Problems
Y N HIV/ AIDS	Y N Difficulty Breathing
Y N Thyroid Disease	Y N Artificial Bones/Joints
Y N High/Low Blood Pressure	Y N Heart Murmur
Y N Severe/Frequent Headaches	Y N Artificial valves
Y N Fainting/Seizures/Epilepsy	Y N Hepatitis
Y N Diabetes/ Tuberculosis	Y N Cancer/Chemotherapy
Y N Heart Surgery/ Pacemaker	Y N Anemia
Y N Miltral Valve Prolapse	Y N Ulcers/Colitis
Y N Venereal Disease	Y N Rheumatic Fever
Y N Shingles	Y N Asthma
Y N Emphysema/Glaucoma	Y N Arthritis

Please list any serious medical condition(s) /Surgeries you have or ever had:

Please list anything that you may be allergic to: _____

Do you exercise regularly? Y N How Much?_____ How long?_____

Do you smoke? Y N How Much?_____ How Long?_____

For Women: Are you taking birth control? Y N

Are You Pregnant? Y N How long? _____ Nursing? Y N

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

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