

# **SYNERGY Therapeutic Group**

www.synergytherapeuticgroup.com

## **MEDICAL HISTORY FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Do you have, or have you had any of the following? (Please circle "yes" or "no")

Diabetes	yes/no
High blood pressure	yes/no
Hysterectomy	yes/no
Hormone replacement therapy	yes/no
Osteoporosis	yes/no
Thyroid disease	yes/no
Heart problems	yes/no
Pacemaker	yes/no
Numbness arms/legs	yes/no
Cancer	yes/no
Sinus problems	yes/no
Arthritis	yes/no
Joint replacements	yes/no
Ringling in your ears	yes/no
Ear fullness/pressure	yes/no
Back/neck pain	yes/no
Problem headaches	yes/no
Breathing problems	yes/no
Eye problems	yes/no
Seizures	yes/no
Stroke	yes/no
Head injuries/auto accident	yes/no
Shingles/cold sores	yes/no

Please list all medication you are taking:

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