

Blue Water Therapy

916 N. Dixie Freeway
New Smyrna Beach, Florida 32168
Phone: 386-426-7885 Fax: 1-866-239-9013
bluewatertherapy1@gmail.com

Medical History

Patient Name: _____ D.O.B _____
Name of Physician: _____ Phone # _____

Are you in good health? Yes No

In the last five years have you been: (if yes, please explain)

- a. Hospitalized? No Yes _____
b. Had a serious illness? No Yes _____
c. Had a major operation? No Yes _____

Please check the following that pertain to you:

- | | |
|---|---|
| <input type="checkbox"/> Heart Surgery, Disease or Attack | <input type="checkbox"/> Surgery/Treatment Tumor/Growth |
| <input type="checkbox"/> Angina Pectoris/Chest Pain | <input type="checkbox"/> AIDS or HIV positive |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Rheumatic Fever/Heart Disease | <input type="checkbox"/> Drug Addiction/Alcoholism |
| <input type="checkbox"/> Heart Murmur/MVP | <input type="checkbox"/> Hemophilia or Excessive Bleeding |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Psychiatric/Mental Disorders |
| <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Knee Replacement |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer or Tumors | <input type="checkbox"/> Sinus Trouble (Sinusitis) |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Lung Disease/Tuberculosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> | |

Other: _____

Please list all allergies or unusual reactions that pertain to you:

Patient Signature _____ Date: _____