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:

□ Heart Surgery, Disease or Attack
□ Angina Pectoris/Chest Pain
□High/Low Blood Pressure
□ Stroke
□ Rheumatic Fever/Heart Disease
□Heart Murmur/MVP
□ Pacemaker
□ Hip Replacement
□ Kidney Disease
□ Cancer or Tumors

□ Thyroid Disease
□ Lung Disease/Tuberculosis
□ Diabetes
□
Other:____
____
____
____

□ Surgery/Treatment Tumor/Growth
□ AIDS or HIV positive
□ Hepatitis, Jaundice or Liver Disease
□ Blood Transfusion
□ Drug Addiction/Alcoholism
□ Hemophilia or Excessive Bleeding
□ Psychiatric/Mental Disorders
□ Knee Replacement
□ Asthma
□ Sinus Trouble (Sinusitis)

□ Seizures/Epilepsy
□ Arthritis

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