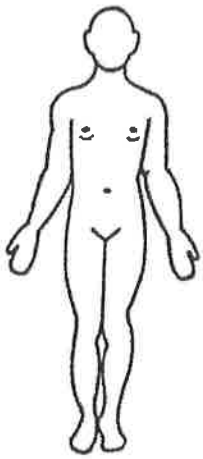
ESOPT MEDICAL INFORMATION

Patient Name:_____ Age: ____ Height: _____ Weight: _____

Dominant Hand: L / R General Physical Condition/Health: Excellent Good Fair Poor

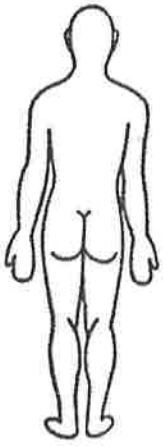
Please describe below and mark on the drawings the area[s] of your chief complaints:

_____
_____
_____
_____
_____
_____



R L

FRONT VIEW



L R

REAR VIEW

_____
_____
_____
_____
_____
_____

Please indicate (**by circling**) if you currently have or have a history of any of the following:

Allergies
Anemia
Anxiety
Arthritis
Asthma
Autoimmune Disorder
Cancer
Cardiac Conditions
Cardiac Pacemaker
Chemical Dependency
Circulation Problems
COVID-19
Currently Pregnant
Depression
Diabetes
Dizzy Spells
Emphysema / Bronchitis
Fibromyalgia
Fractures
Gallbladder Problems
Headaches
Hearing Impairment
Hepatitis
High Cholesterol
High/Low Blood Pressure
HIV/Aids
Incontinence
Kidney Problems
Metal Implants
MRSA
Multiple Sclerosis
Muscular Disease
Osteoporosis
Parkinson's Disease
Rheumatoid Arthritis
Seizures
Smoking
Speech Problems
Strokes
Thyroid
Disease
Tuberculosis
Vision Problems

If you circled YES to any of the above, please explain:_____
_____

Previous surgeries (include approximate date):_____
_____

Please list any medications and the dosage (may use backside or provide a copy to the front desk):_____
_____
_____