

MEDICAL HISTORY

Patient Name:	Height:	Weight:
Family Physician:	Phone Number:	

Please list any medical conditions that you have. If none, please check none. None

Do you have Sleep Apnea? No Yes

Do you use CPAP/BIPAP? No Yes

If so, what are your settings for your machine? _____

Do you have Diabetes? No Yes

Do you have OR have you ever been treated for cancer? No Yes, type: _____

Do you take blood thinners (including aspirin)? No Yes, which one _____

Please list any surgeries or hospitalizations you have had in the past. If none, please check none. None

Please list all medications you are currently taking. (Include birth control pills, vitamins, supplements, etc.)

Please include strength (how many milligrams & how many times a day you take it). If none, please check none. None

Medication	Dose	Frequency	Medication	Dose	Frequency

Please list all medications to which you are allergic and type of reaction you had. If none, please check none. None

Are you allergic to latex? Yes No

Family History

My family members have a history of the following medical problems. Check yes or no.

- | | |
|--|--|
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood vessel disease (circulation problems) <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please circle the correct answer below:

Have you ever been tested for the Aids Virus (HIV)?	Yes	No	If yes, what were the results:	Positive or Negative
Do you smoke?	Yes	No	If yes, how much per day?	
Do you drink alcohol?	Yes	No	If yes, how much per day?	
Do you use social drugs?	Yes	No	If yes, what and how often?	
Have you ever been treated for alcoholism or drug abuse? If so, what? and when?				
Are you pregnant or have any reason to think you might be?				
Yes No				

Review of Systems

Do you have or have had any of the following? Check yes, no or ongoing.

Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Nausea or Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Past Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Artificial Valve.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Prolonged Bleeding from Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Bleeding Tendencies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Rectal Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Blood Transfusions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Rheumatic Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Bone Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Severe Nosebleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Depression.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Stomach Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Think I'm at High Risk for AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Ulcer Disease.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Heart Attack in Past.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Ulcers in Past.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Urination, Frequent.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Heartburn	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Urination, Painful	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Heartburn, Frequent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Urination, Slow.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Veneral Disease.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Irregular Heartbeat.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Wear Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Jaundice.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing	Weight Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing				
Kidney Stones.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing				
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing				
Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Ongoing				

I hereby state that the above information is true and correct to the best of my knowledge.

Signature

Date

Print Name