

Patient Information

Name _____ Date of Birth _____

Gender M F Age _____ Which is your Dominant Hand? Right Left

Past Medical History (Check all that apply)

- | | | |
|---|--|--|
| <p>Heart/Cardiac Disease</p> <p><input type="checkbox"/> heart attack (MI)</p> <p><input type="checkbox"/> angina/chest pain</p> <p><input type="checkbox"/> congestive heart failure</p> <p><input type="checkbox"/> arrhythmia (irregular pulse)</p> <p><input type="checkbox"/> other _____</p>
<p><input type="checkbox"/> high blood pressure</p> <p><input type="checkbox"/> anemia</p> <p><input type="checkbox"/> bleeding disorder</p> <p><input type="checkbox"/> blood clots in leg (DVT) or lung</p> <p><input type="checkbox"/> peripheral vascular disease</p> <p><input type="checkbox"/> peripheral neuropathy</p> <p><input type="checkbox"/> osteoporosis</p> <p><input type="checkbox"/> problems with anesthesia</p> <p><input type="checkbox"/> HIV or AIDS</p> <p><input type="checkbox"/> gout</p> <p><input type="checkbox"/> other _____</p> | <p>Pulmonary/breathing problem</p> <p><input type="checkbox"/> asthma</p> <p><input type="checkbox"/> emphysema (COPD)</p> <p><input type="checkbox"/> chronic bronchitis</p> <p><input type="checkbox"/> pneumonias</p> <p><input type="checkbox"/> pulmonary embolus (clot in lung)</p>
<p><input type="checkbox"/> hepatitis</p> <p><input type="checkbox"/> liver cirrhosis</p> <p><input type="checkbox"/> diabetes</p> <p><input type="checkbox"/> insulin dependent</p> <p><input type="checkbox"/> cancer (type _____)</p> <p><input type="checkbox"/> tuberculosis</p> <p><input type="checkbox"/> osteoarthritis</p> <p><input type="checkbox"/> rheumatoid arthritis</p> <p><input type="checkbox"/> thyroid disorder</p> <p><input type="checkbox"/> psoriasis</p> | <p>GI problems</p> <p><input type="checkbox"/> hiatal hernia</p> <p><input type="checkbox"/> ulcer</p> <p><input type="checkbox"/> irritable bowel</p> <p><input type="checkbox"/> diverticulitis</p> <p><input type="checkbox"/> GERD</p>
<p>Urologic problems</p> <p><input type="checkbox"/> stress incontinence</p> <p><input type="checkbox"/> enlarged prostate</p> <p><input type="checkbox"/> frequent infections (UTIs)</p> <p><input type="checkbox"/> kidney stones</p> <p><input type="checkbox"/> kidney failure</p> <p><input type="checkbox"/> depression/anxiety</p> <p><input type="checkbox"/> seizure / epilepsy</p> <p><input type="checkbox"/> stroke / TIAs</p> <p><input type="checkbox"/> dental infections</p> |
|---|--|--|

Surgical History (List all operations you have had and year) – use back of sheet if needed

_____	_____
_____	_____
_____	_____

Allergies to Medications

Current Medications (Include dosage and frequency) – use back of sheet if needed

_____	_____
_____	_____
_____	_____
_____	_____

Social History Tobacco use _____ packs per day for _____ years (if stopped, when?) _____

Daily Alcohol use? Yes / No Amount _____ Recovered Alcoholic Drug Use: Past Current

Women – Have you reached the menopause yet? Yes / No When? _____

Family History

If any blood relative has suffered any of the following –circle the number and indicate which relative.

- | | | | |
|------------------|-------------------------|--------------------|-------|
| 1) Diabetes | 5) High Blood Pressure | 9) Cancer | _____ |
| 2) Anemia | 6) Back Problems | 10) Osteoporosis | _____ |
| 3) Bleeds easily | 7) Rheumatoid Arthritis | 11) Gout | _____ |
| 4) Heart Disease | 8) Kidney Disease | 12) Kidney Disease | _____ |