Name:_____ Date:_____

DOB: _____ Primary Physician: _____

Daytime Phone Number: _____

Tuberculosis Exposure? Y/N (CIRCLE ONE)

MRSA- STAPH INFECTION? Y/N (CIRCLE ONE) IF YES, WHERE? _____

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

- ☐ Epilepsy/Seizure
- ☐ Depression
- ☐ Bipolar
- ☐ Anxiety
- ☐ Asthma
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Enlarged Prostate
- ☐ Kidney Stones
- ☐ Diverticulitis
- ☐ Gastritis
- ☐ GERD- Reflux - Heartburn
- ☐ Blood Clots
- ☐ Bleeding Disorder - Type

  _____
- ☐ Other _____

  _____

HEART DISEASE INFO

Chest Pain	Y/N- When_____
Congestive Heart Failure	Y/N- When_____
Heart Attack	Y/N- When_____
Catheterization	Y/N- When_____
Heart Stents	Y/N- When_____
Heart Vessel Bypass	Y/N- When_____
Echo/ EKG	Y/N- When_____
Stress Test	Y/N- When_____
Pacemaker/ Defibrillator	Y/N- When_____
Irregular Heart Beat	Y/N- What kind? (I.E. Atrial Fibrillation)

_____

ARE YOU ***ALLERGIC*** TO ANY MEDICATIONS? Y/N

PLEASE LIST REACTIONS.

_____

_____

_____

ARE YOU ALLERGIC TO LATEX? Y/N

Name:_____ Date:_____

DAILY MEDICATION

Names/Doses/ Directions (Include Over the Counter and Aspirin Products)

_____ _____

_____ _____

_____ _____

_____ _____

PERSONAL HISTORY (CIRCLE ONE)

Married Single Divorced Widowed Separated Children #_____

(MARK ALL THAT APPLY)

Tobacco Products Y/N – If Y, # of pack(s) per day_____How many years?_____

Snuff/Chew Y/N _____

Alcohol Y/N – If Y, what kind/how much _____

Street Drugs Y/N – If Y, what type _____

PREVIOUS SURGICAL HISTORY (MARK ALL THAT APPLY)

Endoscopy Y/N When: _____

Colonoscopy Y/N When: _____ Polyps: Y/N Hemorrhoids: Y/N

Gallbladder ☐ Appendix Surgery ☐

Hernia Surgery ☐ Thyroid Biopsy/Surgery ☐

OTHER SURGERIES:

TYPE OF SURGERY YEAR DOCTOR WHERE

_____

_____

_____

FAMILY HISTORY

Does any family member have any medical conditions?

(Mom, Dad, Brother, Sister, Grandparents, Great Grandparents) If so please list:

Heart Disease _____

Diabetes _____

Stroke _____

Thyroid Disease _____

Cancer (What Kind?) _____

Other _____

Mother: Living/ Deceased Age: _____ Father: Living/Deceased Age: _____