

**Past Medical History** - please circle all medical problems you have had in the past:

**EYES**  
 Blindness, Explain  
 Glaucoma

**EARS, NOSE & THROAT**  
 Deafness/Hard of Hearing

**CARDIOVASCULAR**  
 Angina  
 Heart Murmur  
 Mitral Valve Prolapse  
 Heart Attack, date:  
 High Blood pressure  
 High Cholesterol  
 Congestive Heart Failure  
 Stroke, date:  
 Atrial Fibrillation  
 AAA  
 Coronary Artery Disease

**RESPIRATORY**  
 Asthma  
 COPD/Emphysema  
 Tuberculosis, date:  
 Bronchitis  
 Sleep Apnea  
 Pneumonia

**GASTROINTESTINAL**  
 Colitis  
 Colon Polyp  
 Cirrhosis of Liver  
 Diverticulosis/Diverticulitis (circle one)  
 Gallstones  
 Hepatitis, type:  
 Stomach Ulcers  
 Crohn's  
 Hemorrhoids  
 IBS  
 Reflux

**SKIN**  
 Skin Disorder, Explain:  
 Melanoma, date:

**URINARY**  
 Urinary Incontinence  
 Kidney Failure  
 Kidney Stones

**NEUROLOGIC**  
 Epilepsy/Seizures  
 Paraplegia/Quadriplegia  
 Headache  
 Parkinson's

**PSYCH**  
 Depression  
 Alzheimers

**HEMATOLOGIC/LYMPHATIC**  
 HIV/AIDS, date:  
 Poor Blood Clotting  
 Anemia  
 Sickle Cell Anemia  
 Blood Clots legs/lungs

**MUSCULOSKELETAL**  
 Arthritis  
 Fibromyalgia  
 Gout  
 Osteoporosis

**ENDOCRINE**  
 Lupus  
 Thyroid Disorder, type:  
 Diabetes, type:

**CANCER**  
 Type & Date:  
**REPRODUCTIVE**  
 Is there a chance you could be pregnant?  
 Endometriosis  
 Pelvic Inflammatory Disorder

**OTHER CONDITIONS NOT LISTED ABOVE:**  
 \_\_\_\_\_  
 \_\_\_\_\_

**Past Surgical History**  
 Please list all operations you have had in the past:  
 None

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Do you have a Pacemaker or Defibrillator:  
 Yes  No

**Medications**  
 Please list all your current medications you are presently taking (include doses):  
 None

| Medication | Strength | Dose |
|------------|----------|------|
|            |          |      |
|            |          |      |
|            |          |      |
|            |          |      |
|            |          |      |
|            |          |      |
|            |          |      |
|            |          |      |

**Allergies**  
 Please list all medicines you are allergic to or have a reaction to:  
 Latex  None

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family Medical History**  
 Please list all medical problems which run in your family:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Will you accept blood or blood products?  
 Yes  No

**Habits**  
 Do you smoke cigarettes?  
 No  
 Occasionally  
 1/2 ppd  
 1 ppd

If you smoked in the past, when did you quit?  
 Caffeine intake  
 Amount: \_\_\_\_\_

Do you drink alcohol?  
 Never  
 Occasionally  
 a few times a week  
 daily

IV Drug Use  
 Never  
 Occasionally  
 a few times a week  
 daily

Have you recently had any of the following symptoms? Please circle all that apply:

**GENERAL**  
 weight loss - weight gain  
 fever  
 excessive thirst  
 sweats  
 chills  
 decreased appetite  
 enlarged lymph nodes  
 fatigue

**EYES**  
 loss of vision  
 double vision

**EARS, NOSE & THROAT**  
 hearing loss  
 nose bleed  
 sinus congestion  
 hoarseness  
 sore throat  
 sinus problems  
 trouble swallowing

**LUNGS**  
 chronic cough  
 coughing blood  
 painful breathing  
 recent cold  
 shortness of breath  
 coughing phlegm  
 wheezing

**HEART**  
 irregular heart beat  
 chest pain  
 palpitations  
 swelling in feet

**STOMACH/INTESTINES**  
 abdominal pain  
 abdominal bloating  
 constipation  
 diarrhea  
 change in stools  
 heartburn  
 nausea  
 rectal bleeding  
 vomiting

**KIDNEY/GENITALS**  
 painful urination  
 bloody urine

**MUSCLES/BONES**  
 joint pain  
 arthritis

**NERVOUS SYSTEM**  
 headache  
 numbness  
 tingling  
 dizziness

**SKIN**  
 jaundice  
 rash

**BREAST**  
 breast discharge  
 breast pain

**PSYCHIATRIC**  
 depression  
 insomnia

**BLOOD**  
 easy bleeding

**OTHER:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_