Patient Name:_____ Sex:_____Age: _____

Height: _____Weight:_____ Usual Blood Pressure: _____

Family Physician:_____ Referred by: _____

PLEASE LIST ALL:

Prior Surgeries:

Medical Problems, Current or Past:

Current Medications:

Allergies (Medications, Latex or Environmental)

Family History - Medical Conditions (Such as Diabetes, Heart Disease, Cancer, High Blood Pressure, Asthma, Hearing Loss, Bleeding Tendencies)

PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS:

			Review Date (Office Use Only)
Do you take aspirin on a daily basis?	❑ YES	❑ NO	_____
Do you have any bleeding tendencies?	❑ YES	❑ NO	_____
Have you had or do you have asthma?	❑ YES	❑ NO	_____
Have you ever smoked? How long?_____ How much?_____	❑ YES	❑ NO	_____
When did you quit?_____	❑ YES	❑ NO	_____
Have you taken any cortisone or steroids in past 6 months?	❑ YES	❑ NO	_____
Do you have a heart murmur?	❑ YES	❑ NO	_____
Have you ever had a heart attack?	❑ YES	❑ NO	_____
Have you ever had angina or palpitations?	❑ YES	❑ NO	_____
Are you under treatment for high blood pressure?	❑ YES	❑ NO	_____
Have you ever had a stroke?	❑ YES	❑ NO	_____
Have you had epilepsy, seizures, or fainting spells? (Circle which one)	❑ YES	❑ NO	_____
Have you ever had any thyroid difficulties?	❑ YES	❑ NO	_____
Have you ever had hepatitis?	❑ YES	❑ NO	_____
Do you have any immune disorders?(Which one) _____	❑ YES	❑ NO	_____
Do you have diabetes?	❑ YES	❑ NO	_____
Do you have kidney disease?	❑ YES	❑ NO	_____
Do you have any eye disease? (Which one) _____	❑ YES	❑ NO	_____
Do you have heartburn, hernias, or any ulcers? (Circle which one)	❑ YES	❑ NO	_____
Do you drink alcohol on a daily basis? How Much? _____	❑ YES	❑ NO	_____