PATIENT NAME :_____ SEX :_____ AGE: _____

HEIGHT: _____ WEIGHT:_____ USUAL BLOOD PRESSURE:_____
(IF KNOWN)

FAMILY PHYSICIAN :_____ REFERRED BY:_____

PLEASE LIST ALL:

PRIOR SURGERIES:

MEDICAL PROBLEMS THAT YOU HAVE HAD OR PRESENTLY HAVE:

MEDICATIONS YOU CURRENTLY TAKE:

ALLERGIES TO MEDICATIONS:

ENVIROMENTAL ALLERGIES:

FAMILY HISTORY - MEDICAL CONDITIONS: (Such as Cancer, Diabetes, Heart, High Blood Pressure, Asthma, Hearing Loss, Bleeding Tendencies)

PLEASE CIRCLE YES / 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?_____		
☐ 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 ever 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? _____	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 any heartburn, hernias, or any ulcers? (circle which one)	YES	NO
☐ Do you drink alcohol on a daily basis? _____	YES	NO