

GENERAL HEALTH INFORMATION

Patient Name: _____ Date of Birth _____

Height: _____ Weight: _____

Primary Medical Doctor: _____

Address	City	State	Zip
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Past Medical History

Do you now have or have you ever had any of the following disorders? [**check only what applies**]

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Anemia / Blood Disorder |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Nerve Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Decreased Vision |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Dry Eye |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Excessive Tearing |
| <input type="checkbox"/> Other Lung Disease | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Wound Healing Problems |

Any conditions or illnesses not listed above?

Surgical: Please list all operations you have had. Include hospitals and dates if known

Medications: Please list all medications you are currently taking (include over the counter medications, vitamins/supplements, etc.)

Do You Take Aspirin daily? _____ **Vitamins?** _____ **Blood Thinners?** _____

Allergies: Drug Allergies (list)

Other: (latex, tape, iodine, soaps, etc)

Other: Do you smoke? Yes or No

Approx. packs/day _____

Signature

Date