MEDICAL HISTORY - *Please read carefully and be thorough, Thank You.*

Please check all that apply, circle where appropriate and write in the type

- [ ] Heart Failure
- [ ] Heart Attack
- [ ] Angina Pectoris
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] High Cholesterol
- [ ] Heart Murmur
- [ ] Scarlet Fever
- [ ] Rheumatic Fever
- [ ] Mitral Valve Prolapse
- [ ] Heart Pacemaker
- [ ] Heart Surgery
- [ ] Artificial valve / stent
- [ ] Congenital Heart Lesion
- [ ] Anemia – Type:
- [ ] Blood Disease - Type:
- [ ] Circulatory Problems
- [ ] Emphysema
- [ ] Chronic cough
- [ ] Shortness of breath
- [ ] Tuberculosis / Positive PPD test
- [ ] Asthma
- [ ] Hay Fever
- [ ] Hives
- [ ] Respiratory Disease - Type:
- [ ] Diabetes Type I Type II
- [ ] Thyroid Disease Hyper Hypo
- [ ] Liver Disease
- [ ] Jaundice
- [ ] Hepatitis A B C
- [ ] Liver / Kidney / Heart Transplant
- [ ] Venereal Disease - Type:
- [ ] Cold Sores
- [ ] Positive Test for HIV
- [ ] Chemotherapy
- [ ] Radiation Treatment
- [ ] Cancer – Type:
- [ ] Unexplained Weight Loss
- [ ] Tumor – Type:
- [ ] Special Diet
- [ ] Stroke / TIA
- [ ] Epilepsy
- [ ] Seizures
- [ ] Headaches
- [ ] Nervous Problems
- [ ] Psychiatric Care
- [ ] Fainting / Dizzy Spells
- [ ] Ulcers
- [ ] Arthritis
- [ ] Artificial Joint
- [ ] Rheumatism
- [ ] Blood Transfusion / Dialysis
- [ ] Blood/Thinners (Coumadin)
- [ ] Aspirin taken daily
- [ ] Other – Please Explain: ____________________

____

Please list any diseases, conditions or surgeries you have or had that are not listed above.

____

ALLERGIES - *Check all that apply – Thank You!*

Please check all that apply, circle where appropriate and write in the type

- [ ] Local Anesthetics
- [ ] Penicillin / Antibiotics
- [ ] Sulfa drugs
- [ ] Barbiturates
- [ ] Latex
- [ ] No allergies
- [ ] Sedatives
- [ ] Iodine
- [ ] Aspirin
- [ ] Chocolate
- [ ] Other - ____________________

You made it to the bottom of the form…You're almost done! Please flip this page over… Thanks!

Please check all that apply, circle where appropriate and write in the type

When you walk upstairs / take a walk do you have to stop due to pain in your chest, shortness of breath or fatigue? Yes No

Do you bruise easily? Yes No

Have you ever had excessive bleeding requiring special treatments? Yes No

Do you use tobacco products? Yes No

Do you use recreational drugs? Yes No

Are you pregnant? Yes No

Are you nursing? Yes No

Are you taking Birth Control Pills? Yes No

Do you have osteoporosis *or* have you ever taken the following: *(please circle all that apply)*

Fosamax | Didronel | Boniva | Actonel | Skelid | Zometa | Aredia

Medical Doctors Name:	**Phone #:**

CURRENT MEDICATIONS *Please include all prescribed, over the counter, herbal supplements and vitamins*

1	6	11	16
2	7	12	17
3	8	13	18
4	9	14	19
5	10	15	20

Patient or Guardian Signature **Date**

For Office Use Only: BP ASA Class I II III IV Doctor Signature:

PATIENT INFORMATION - CONFIDENTIAL

Name: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Domestic Partner**

FIRST MI LAST

Address:	**Employers Name & Address:**
CITY STATE ZIP CODE	CITY STATE ZIP CODE
Home Phone:	**Work Phone** **EXT.:**

Cell Phone:

Person to Contact in Case of Emergency: **Phone:**

INSURANCE INFORMATION

Insurance Company:	**Insurance Policy Group #:**
Name of Primary Subscriber:	**Relationship to You:**
Insured Parties ID # or Social Security #:	**Birth Date:**
Insurance Company Phone Number #:	