

If you previously had any of the following procedures, please list the date and place they were performed:

PROCEDURE	DATE	PLACE PERFORMED
X-Rays		
C.T./MRI		
Myelogram		
Ultrasound		

<b>Current Medications:</b> Please list all medications you are currently taking (Prescription and over-the-counter)	
Name of Medication/Strength	# Of Doses/Day

<b>HOSPITALIZATION AND SURGERY</b>
Please list all surgery and periods of hospitalization

What medications are you allergic to? \_\_\_\_\_

Do you have implants?  Yes  No Pacemaker?  Yes  No Defibrillator?  Yes  No

<b>Women Only</b>	Can you become pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please provide the date of your last:
If not, why?		Mammogram:
Date of last period:	Normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pap smear:
Are you now or could you be pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Do you now or have you ever: (This is confidential information we need to treat you properly)**

Smoke?  Yes  No  Stopped Packs per day? \_\_\_\_\_  
 Use alcohol?  Yes  No Type and amount? \_\_\_\_\_  
 Drink coffee/cafeine?  Yes  No Type and amount? \_\_\_\_\_  
 Use recreational drugs?  Yes  No Type and frequency? \_\_\_\_\_

**Please mark any condition that you now have or have recovered from in the past:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Severe headaches    | <input type="checkbox"/> Chest pain/angina          | <input type="checkbox"/> Kidney stones            | <input type="checkbox"/> Digestive problems    |
| <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Heart palpitations         | <input type="checkbox"/> Renal disease            | <input type="checkbox"/> Gout                  |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Heart murmur               | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Arthritis             |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Arrhythmia                 | <input type="checkbox"/> Endocrine disease        | <input type="checkbox"/> HIV/AIDS              |
| <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Congenital heart disease   | <input type="checkbox"/> Urinary/genital problems | <input type="checkbox"/> Claudication          |
| <input type="checkbox"/> Dizziness/fainting  | <input type="checkbox"/> Rheumatic or scarlet fever | <input type="checkbox"/> Prostate problems        | <input type="checkbox"/> Ulcer                 |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Gall stones                | <input type="checkbox"/> Sexual dysfunction       | <input type="checkbox"/> Venereal disease      |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pancreatitis               | <input type="checkbox"/> Menstrual dysfunction    | <input type="checkbox"/> Mental illness        |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Liver disease              | <input type="checkbox"/> Ovarian cysts            | <input type="checkbox"/> Alcohol/drug problems |

**FAMILY HISTORY: Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had:**

Condition	Who?	Condition:	Who?
Heart disease		Epilepsy	
Hypertension		Glaucoma	
Stroke		Bleeding disorders	
Cancer		Kidney disease	
Diabetes		Thyroid disease	

