PATIENT INFORMATION

Date________________________

Name____Name to be called____________________

Birthday____/____/____Age______________Sex______________Marital Status________________

Height______________Weight____________Occupation________________________________

Family Physician__________________________Referring Physician________________________

Chief Complaint:____

Have You Had:

1. High Blood Pressure	YES	NO	2. Pulmonary Disease	YES	NO
3. High Cholesterol	YES	NO	4. Asthma/Shortness of Breath	YES	NO
5. Heart trouble	YES	NO	6. Emphysema	YES	NO
7. Heart Attack/Stroke	YES	NO	8. Sleep Apnea	YES	NO
9. Chest Pain	YES	NO	10. Diabetes	YES	NO
11. Irregular Heart Beat	YES	NO	12. Jaundice or Hepatitis	YES	NO
13. Congestive Heart Failure	YES	NO	14. Kidney Disease	YES	NO
15. Abnormal EKG	YES	NO	16. Thyroid Disease	YES	NO
17. Gastric Reflux	YES	NO	18. Bleeding Problems	YES	NO
19. Hiatal Hernia/Ulcers	YES	NO	20. Numbness or Weakness	YES	NO
21. Epilepsy or Seizures	YES	NO	22. Arthritis/Rheumatoid Arthritis	YES	NO
23. Psychological Problems	YES	NO	24. Emotional Problems	YES	NO
25. Motion Sickness	YES	NO	26. Body Piercing/Metal in Body	YES	NO

27. Any contagious disease, including HIV or MRSA YES NO

28. Most recent EKG ____________________Where ________________________________

DO YOU

1. Wear Dentures, Partials, Crowns or have loose teeth YES NO
2. Have legal Guardianship, Power of Attorney, or a Living Will YES NO
3. Drink Alcohol YES NO How much? ________________________________
4. Smoke YES NO How much? ________________________________

LIST ALL MEDICATIONS, INCLUDING OVER THE COUNTER

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LIST PRIOR SURGERIES

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ALLERGIES

Medication Allergies? YES NO List: ____

____

Food Allergies? YES NO List: ____

____

Latex or Tape Allergies? YES NO List: ____

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Family History of Heart Disease, blood pressure, diabetes, etc.______________________

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BP ____________________PULSE____________________TEMP____________________