

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex : Female Male Marital Status: M W S D

Please list any food allergies:

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Please list any current medications you are taking:

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Please list any recent surgical procedures:

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Do you have now, or have you ever had any of the following conditions:

<b>Lungs</b>	<b>Yes</b>	<b>No</b>	<b>Other Systematic</b>	<b>Yes</b>	<b>No</b>
Bronchitis	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>
Emphysema	<input type="radio"/>	<input type="radio"/>	Thyroid	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Kidney	<input type="radio"/>	<input type="radio"/>
Chronic Cough	<input type="radio"/>	<input type="radio"/>	Bladder	<input type="radio"/>	<input type="radio"/>
Morning Cough	<input type="radio"/>	<input type="radio"/>	Stomach	<input type="radio"/>	<input type="radio"/>
			Bowel	<input type="radio"/>	<input type="radio"/>
<b>Vascular</b>	<b>Yes</b>	<b>No</b>	Hepatitis or Yellow Skin	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>
Chest Pain	<input type="radio"/>	<input type="radio"/>	Arthritis/Joint Deformity	<input type="radio"/>	<input type="radio"/>
Heart Attack	<input type="radio"/>	<input type="radio"/>	Convulsions, Epilepsy, or Seizures	<input type="radio"/>	<input type="radio"/>
Heart Murmur	<input type="radio"/>	<input type="radio"/>	Fainting	<input type="radio"/>	<input type="radio"/>
Irregular Heartbeat	<input type="radio"/>	<input type="radio"/>			
Pacemaker	<input type="radio"/>	<input type="radio"/>			
Phlebitis	<input type="radio"/>	<input type="radio"/>			

Do you drink alcohol?      Yes    No    If yes, number of drinks per week \_\_\_\_\_

Do you use IV drugs?      Yes    No    If yes, what \_\_\_\_\_ How often? \_\_\_\_\_

Do you smoke?      Yes    No    If yes how often? \_\_\_\_\_

Do you bleed easily?      Yes    No    (Women) Are you pregnant?    Yes    No    if yes, due date: \_\_\_\_\_