NAME_____ Date_____

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you. **Do you have a history of:**

1. Unexplained weight loss YES___NO___
2. Fever or chills YES___NO___
3. Night sweats YES___NO___
4. Skin rashes YES___NO___
5. Head trauma YES___NO___
6. Frequent headaches YES___NO___
7. Double or blurry vision YES___NO___
8. Hearing loss YES___NO___
9. Ringing in ears YES___NO___
10. Nasal congestion YES___NO___
11. Hoarseness YES___NO___
12. Sore throat YES___NO___
13. Swollen glands YES___NO___
14. Breast masses or lumps YES___NO___
15. Wheezing YES___NO___
16. Shortness of breath YES___NO___
17. Coughing YES___NO___
18. High blood pressure YES___NO___
19. Heart murmur YES___NO___
20. Palpitations YES___NO___
21. Stroke YES___NO___
22. Chest pain YES___NO___
23. Heartburn YES___NO___
24. Heart attacks YES___NO___
25. Congestive heart failure YES___NO___
26. Pacemaker or defibrillator YES___NO___
27. Cardiac stents YES___NO___
28. Abdominal pain YES___NO___
29. Fibromyalgia YES___NO___
30. Stomach/intestinal ulcers YES___NO___
31. Change in bowel habits YES___NO___
32. Urinary frequency YES___NO___
33. Incontinence YES___NO___
34. Thyroid problems YES___NO___
35. Diabetes YES___NO___
36. Hepatitis YES___NO___
37. Muscle weakness YES___NO___
38. Leg swelling YES___NO___
39. Varicose veins YES___NO___
40. Blood clots YES___NO___
41. Anxiety YES___NO___
42. Depression YES___NO___
43. Memory loss YES___NO___
44. Hernias YES___NO___
45. Menstrual problems YES___NO___
46. Bleeding problems YES___NO___
47. Unusual post-op bleeding YES___NO___
48. Anesthesia problems YES___NO___
49. Cancer YES___NO___
50. Malignant hyperthermia YES___NO___
51. HIV OR AIDS YES___NO___
52. Metal in eyes YES___NO___
53. Brain aneurysm clip YES___NO___
54. Cochlear implants YES___NO___
55. Sleep apnea YES___NO___
56. Asthma YES___NO___
57. Do you smoke?_____ Have you ever?_____How much?_____
58. Do you drink alcohol?_____Have you ever?_____How much?_____
59. Recreational drug use?_____Explain_____
60. Does any family member suffer from any medical problems?_____
61. Does any blood relative have a history of malignant hyperthermia or any other anesthesia Problems? YES_____ NO_____
62. Do you have an Advance Directive? YES_____NO_____
63. Females – Did you ever have a bone density test (DEXA) YES_____NO_____ DATE_____
64. Did you get the pneumonia vaccine? YES_____ NO_____Date_____
65. Do you suffer from depression? YES_____NO_____

THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY BELIEF.

_____ _____

PATIENT SIGNATURE **DOCTOR SIGNATURE**