Past Medical History

Name:_____ Date:_____

This form **MUST** be filled out **COMPLETELY**: If it does not pertain, please put **N/A.**

CHECK ALL THAT APPLY ONLY:

High blood pressure**( )** Diabetes**( )** High Cholesterol**( )** Gout**( )** HIV or AIDS**( )**

Asthma**( )** Liver Disease**( )** Kidney Disease**( )** COPD**( )** CHF**( )** Hepatitis C**( )**

Sexually Transmitted Disease (STD)**( )** Which one: _____

Blood clotting problems Sickle Cell Anemia**( )** Rheumatoid Arthritis**( )**

Hypothyroid**( )** Migraines**( )** Gastroesophageal Reflux (GERD)**( )**

Defibrillator**( )** Pacemaker**( )** Mitral Valve Prolapse**( )** Arrhythmias**( )**

Sleep Apnea**( )** Seizures**( )** Depression**( )** Which one: _____

Anxiety Disorder**( )** Other: (Please explain):

CHECK ALL THAT APPLY FOR SURGICAL PROCEDURES you have had:

Gallbladder**( )** Appendectomy**( )** Hysterectomy**( )** Tubal Ligation**( )** Tonsillectomy**( )** Hernia Repair**( )** Hemorrhoidectomy**( )** Knee Arthroscopy**( )** Left/Right (please circle)

Back**( )** Cervical**( )** Shoulder Arthroscopy**( )** Left/Right (please circle) Heart Stent**( )**

Coronary Artery Bypass Graph(CABG)**( )** Other (Please explain):

List drug **ALLERGIES** and **REACTIONS**: _____

Do you live (Please check):
( ) Alone
( ) With Family
( ) Nursing Home
( ) Assisted Living

Do you smoke or chew tobacco? **( )**Yes **( )** No

Do you drink alcohol? **( )**Yes **( )** No

Do you currently use illegal drugs?**( )**Yes **( )** No
If yes, list the substance and how often: _____