PLEASE CHECK ALL THAT APPLY.

PAST MEDICAL HISTORY: Have you ever been diagnosed BY A DOCTOR with any of the following:

HEENT:
- ☐ Cataract
- ☐ Migraine Headaches

Cardiovascular:
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Peripheral Vascular Disease
- ☐ HTN (High Blood Pressure)
- ☐ CHF (Congestive Heart Failure)

Endocrine:
- ☐ Diabetes
- ☐ Thyroid Disorders

GU:
- ☐ Kidney Infections
- ☐ Kidney Failure

GI:
- ☐ Gastric Ulcer
- ☐ Acid Reflux
- ☐ Hiatal Hernia

Hematologic:
- ☐ Anemia
- ☐ Blood Transfusions
- ☐ DVT (Blood Clot)
- ☐ Hepatitis
- ☐ HIV

Neuro:
- ☐ Seizures
- ☐ CVA (stroke) yr_____
- ☐ Peripheral Neuropathy

Neoplasm:
- ☐ Cancer

Musculoskeletal:
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoporosis
- ☐ Fractured Bones

List Here _____

Pulmonary:
- ☐ Chronic Obstructive Pulmonary Dz (COPD)
- ☐ Asthma
- ☐ Pneumonia

OTHER _____

ALL Previous Surgeries: ☐ **NONE**

☐Tonsils ☐Appendix ☐Gallbladder ☐Stent ☐Heart Bypass ☐Right Total Hip ☐Left Total Hip
☐Right Total Shoulder ☐Left Total Shoulder ☐Right Total Knee ☐Left Total Knee

Other Surgeries Not Listed: _____

_____

REVIEW OF SYMPTOMS: Are you CURRENTLY having any of the following symptoms:

Systemic:
- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue

HEENT:
- ☐ Headache

Cardiac:
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Cold Hands or Feet

Endocrine:
- ☐ Temperature Intolerance
- ☐ Excessive Thirst

GI:
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Trouble Swallowing

GU:
- ☐ Urinary Loss of Control
- ☐ Pain with Urination
- ☐ Frequent Urination

Hematologic:
- ☐ Bleeding Problems
- ☐ Easy Bruising Tendency

Musculoskeletal:
- ☐ Night Cramps

Neuro:
- ☐ Difficulty Keeping Balance
- ☐ Memory Lapse or Loss
- ☐ Numbness
- ☐ Tingling

Pulmonary:
- ☐ Shortness of Breath

Psych:
- ☐ Feeling Depressed
- ☐ Anxiety

Skin:
- ☐ Skin Rash
- ☐ Skin Redness

I UNDERSTAND THIS INFORMATION WILL BECOME A PART OF MY PERMANENT RECORD.

Signature: _____ **Date:** _____