



Medical Data

Medical History: (Check all that apply to **YOU** past and present)

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hypotension | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bowel/Bladder problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Cancer (list below) | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Immunodeficiency | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Other (list below) | <input type="checkbox"/> Edema | <input type="checkbox"/> Stomach Pain |

Surgical History: (List **all** surgeries you have had)

Do you take any "Blood Thinners": NO YES – please list _____

Known Drug Allergies: _____

Known Food Allergies: _____

Know Latex Allergy: NO YES –What happens? _____

Do you have (or recently had): (Check all that apply)

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fever/Chills |
| <input type="checkbox"/> Sleeping difficulty | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Urine incontinence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Other (list below) | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Depression |

Do you Smoke? No Yes-How much? _____

Do you drink Alcoholic Beverages? No Yes-How much? _____

Do you use any "street drugs"? No Yes - What/When? _____