Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_

**CHECK YES OR NO TO ALL MEDICAL CONDITIONS BELOW**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **No** | **Yes** |  | **No** | **Yes** |  |
|  |  | Asthma |  |  | Hypothyroidism |
|  |  | Allergies |  |  | Diabetes |
|  |  | COPD |  |  | Obesity |
|  |  | Sleep apnea, do you use CPAP? |  |  | Osteoarthritis |
|  |  | Hypertension |  |  | Rheumatoid arthritis |
|  |  | Coronary artery disease |  |  | Gout |
|  |  | Congestive heart failure |  |  | Fibromyalgia |
|  |  | History of heart attack, when |  |  | Anxiety |
|  |  | Pacemaker/defibrillator |  |  | Depression |
|  |  | Atrial fibrillation |  |  | PTSD |
|  |  | History of pulmonary embolism, when |  |  | Attempted suicide |
|  |  | History of DVT, when |  |  | Anorexia/bulemia |
|  |  | Stroke, when |  |  | Dementia |
|  |  | Edema (swelling) |  |  | Delayed wound healing |
|  |  | Varicose veins |  |  | Keloids |
|  |  | Anemia |  |  | Cellulitis |
|  |  | Hemophilia |  |  | Sepsis |
|  |  | Hypercholesterolemia |  |  | Dementia |
|  |  | Blood transfusion |  |  | History of unexplained stillborn infant |
|  |  | Hepatitis C |  |  | 3 or more miscarriages |
|  |  | HIV/AIDS |  |  | Melanoma, when |
|  |  | Herpes |  |  | Basal or squamous cell carcinoma |
|  |  | Tuberculosis |  |  | Cancer, type |
|  |  | MRSA |  |  | Organ transplant |
|  |  | Family history of pulmonary embolism or DVT |  |  | Personal or family history of malignant hyperthermia |

Please list any other medical conditions you have not listed above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you see a cardiologist? If yes, who \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women only- When was your last mammogram \_\_\_\_\_\_\_\_\_ Was it normal □No □ Yes

Do you drink alcohol □ No □ Yes, drinks per week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke cigarettes □ Never □ Former smoker, quit when \_\_\_\_\_\_\_ □ Yes, cigarettes per day\_\_\_\_\_\_

Do you smoke or use any form of marijuana □ No □Yes, type and frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any illicit drugs □ No □ Yes, type and frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated for substance abuse □ No □ Yes, when and type of substance\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications □ No □Yes, please list medication allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all of the medications (over the counter and prescription) you take regularly

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Frequency | Reason for Medication |
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If you take opioids (pain medication) on a regular basis, are you in a contract with a pain management specialist? □ No □Yes, who \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all major surgeries

|  |  |
| --- | --- |
| Surgery | Date |
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