Medical History

Past Medical History (current or ongoing medical problems)

☐ I have no previous medical problems
☐ High blood pressure ☐ heart attack ☐ CAD ☐ pacemaker ☐ heart Stent
☐ COPD/ emphysema ☐ sleep apnea ☐ oxygen use ☐ pulmonary embolism ☐ asthma
☐ Diabetes ☐ Thyroid disorder ☐ Osteoporosis ☐ GERD ☐ reflux ☐ IBS
☐ Frequent urinary infections ☐ kidney stones ☐ prostate problems ☐ DVT
☐ osteoarthritis ☐ rheumatoid arthritis
☐ Stroke/CVA/ TIA ☐ Seizures ☐ aneurysms ☐ brain injury ☐ neuropathy ☐
Cancer: ☐ lung ☐ breast ☐ prostate ☐ colon ☐ lymphoma ☐ other:
Others:

Past Surgical History or ☐ No previous surgeries
☐ Appendix ☐ tonsils & adenoids ☐ Gallbladder ☐ Hip replacement ☐ Knee replacement ☐ Brain surgery ☐ Hysterectomy ☐ Tubal Ligation ☐ problems with anesthesia
☐ Neck or Back surgery Type:_____
☐ Other:_____

Social History (☐ None of the below)
☐ Current or previous smoker/tobacco use. Packs/ day_____, How many years?_____
☐ Alcohol use: Drinks/day _____, Drinks/week_____
☐ Recreational drugs use

Family History
☐ Back or Spine problems ☐ Bleeding disorders ☐ Heart Disease ☐Diabetes ☐ Aneurysms ☐ Stroke/TIA ☐ Cancers
Other:

Allergies: (please list) ☐ No Known Drug Allergies	**Please list reaction**