

Please list any prior surgeries:

Surgery	Date	Physician	Hospital

Please list all current medications or provide us with your list so we may photocopy it:

Medicine	Dose	Frequency

Do you have any drug allergies? yes no If yes, check below:

- latex
- penicillin
- sulfa
- "mycin"
- aspirin
- codeine
- tetanus
- demerol
- other medications _____

Do you smoke or use tobacco currently? no yes

In the past? no yes
If yes, how much (per day)? _____

Do you use alcohol currently? no occasionally daily

In the past? no yes

Do you exercise? no occasionally regularly

Do you have any other special needs of which we should be aware? no yes

If yes, please describe? _____

What type of work do you do? _____

Has any blood relative ever had any of the following conditions? If yes, please check below:

- NONE**
- Seizures
- Cancer
- Breast Cancer
- Tuberculosis
- Diabetes
- Heart trouble
- High blood pressure
- Stroke
- Mental illness
- Suicide
- Birth defects
- Kidney troubles
- Kidney stones
- Bladder
- Any heritable disease

Currently are you experiencing any of the following symptoms? If yes please check below:

- NONE**
- Severe headaches
- Ringing in the ears
- Dizziness
- Fainting spells
- Blind spells
- Chest pain
- Breast pain, discharge or masses
- Spitting up blood
- Chronic cough
- Shortness of breath
- Fever
- Severe indigestion
- Jaundice
- Diarrhea
- Rectal bleeding
- Bleeding tendencies

What is your current height _____ and weight _____

Any recent changes? _____

Do not write below this line

I have reviewed the above information.

Additional Information

_____	_____
_____	_____
_____	_____
_____	_____