



What is your occupation? \_\_\_\_\_

How many years of school? \_\_\_\_\_

When was your last tetanus shot? \_\_\_\_\_

**Past Family History** – Please check of the following medical problems anyone of your immediate family (mother, father, bother, sister, grandparents) has had:

- |  |                                     |  |  |
|--|-------------------------------------|--|--|
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Heart Problems    | <input type="checkbox"/> Anesthesia problems |
| <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Bleeding Problems |  |

**Review of Systems** – Please check any of the following that you have:

**General:**

- Excessive thirst
- Fainting spells
- Skin rash
- Bruise Easily

**Respiratory:**

- Shortness of breath
- Cough
- Wheezing

**Gastrointestinal:**

- Constipation
- Stomach pain or burning
- Difficulty swallowing
- Frequent loose stools

**Musculoskeletal:**

- Muscle Pain
- Joint Pain
- Trouble Walking
- Use cane or walker
- Loss of sensation in feet
- Extremity Swelling
- Extremity weakness

**Head/Ears/Eyes:**

- Hearing aid
- Corrective eyewear
- Trouble hearing

**Cardiovascular:**

- Palpitations or fluttering heart
- Chest Pain

**Neuro. / Psych.:**

- Severe headaches
- Difficulty Sleeping
- Anxiety or depression

**Genitourinary:**

- Excessive urination
- Burning with urination

**Past Medical History** – Please check any of the following you have currently or previously:

- |  |   |   |  |   |
|--|---|---|--|---|
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Heart problems     | <input type="checkbox"/> Bleeding problems    | <input type="checkbox"/> Blood clots phlebitis | <input type="checkbox"/> Irregular heartbeat  |
| <input type="checkbox"/> Varicose veins        | <input type="checkbox"/> Stroke             | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Kidney failure     | <input type="checkbox"/> Psoriasis            | <input type="checkbox"/> Gout                  | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Urinary infections | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Colitis               | <input type="checkbox"/> Hiatal hernia        |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Stomach ulcers     | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Liver problems        | <input type="checkbox"/> Thyroid problems     |
| <input type="checkbox"/> HIV / AIDS            | <input type="checkbox"/> Other infections   |   | <input type="checkbox"/> Psychiatric problems  | <input type="checkbox"/> Cancer               |

Other: \_\_\_\_\_  
\_\_\_\_\_

Please describe any past surgeries (and year) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: _____
DOB: _____