PERSONAL HISTORY		
AIDS/HIV	YES	NO
Alcoholism	YES	NO
Alzheimer’s	YES	NO
Anxiety	YES	NO
Arthritis	YES	NO
Asthma	YES	NO
Blood Clots	YES	NO
Blood Disorder	YES	NO
Cancer	YES	NO
Cysts	YES	NO
Chronic Pain	YES	NO
COPD	YES	NO
Depression	YES	NO
Diabetes	YES	NO
Emphysema	YES	NO
Gout	YES	NO
Hard of Hearing	YES	NO
Headaches	YES	NO
Heart Failure	YES	NO
Heart Attack	YES	NO
High Blood Pressure	YES	NO
High Cholesterol	YES	NO
Irreg. Heart Rate	YES	NO
Osteoarthritis	YES	NO
Osteoporosis	YES	NO
Parkinson's	YES	NO
Raynaud’s Disease	YES	NO
Rheumatoid Arthritis	YES	NO
Seizures	YES	NO
Stroke	YES	NO
Thyroid Disorder	YES	NO
Ulcers	YES	NO

FAMILY HISTORY			
Check the box under the family member having the condition			
	Mother	Father	Sibling/s
Alcoholism			
Alzheimer’s			
Asthma			
Cancer			
CVA (Stroke)			
Diabetes			
Heart Disease			
High Cholesterol			
High Blood Pressure			
Osteoarthritis			
Problem With Anesthesia			
Rheumatoid Arthritis			
Seizures			
Thyroid Disorder			

DO YOU: *(circle yes or no)*		
Have A Pacemaker?	YES	NO
Take Aspirin?	YES	NO
Take Coumadin?	YES	NO
Have Drug Allergies?	YES	NO

ARE YOU ALLERGIC TO:		
Latex	YES	NO
Penicillin	YES	NO
Sulfa	YES	NO
Erythromycin	YES	NO
Codeine	YES	NO
Iodine	YES	NO
Contrast Dye	YES	NO

<u>**OTHER ALLERGIES**</u> (List):

ARE YOU HAVING ANY OF THE FOLLOWING? *(ANSWER ALL)*

Joint Stiffness	YES	NO	**Anxiety**	YES	NO
Joint Pain	YES	NO	**Depression**	YES	NO
Joint Swelling	YES	NO	**Insomnia**	YES	NO
Cold Intolerance	YES	NO	**Chest pain**	YES	NO
Thyroid Problems	YES	NO	**Irregular heartbeat**	YES	NO
Diabetes	YES	NO	**Heart murmur**	YES	NO
Numbness	YES	NO	**Recent infections**	YES	NO
Muscle Weakness	YES	NO	**Cough**	YES	NO
Poor Coordination	YES	NO	**Known TB Exposure**	YES	NO
Bleeding Easily	YES	NO	**Fever**	YES	NO
Bruising Easily	YES	NO	**Weakness**	YES	NO
Cuts Slow to Heal	YES	NO	**Chills**	YES	NO
Skin Rash	YES	NO	**Asthma**	YES	NO
Skin Lesions	YES	NO	**Seasonal Allergies**	YES	NO
Skin Infection	YES	NO			

<u>Are You Under the Care of A :</u> **Pain Specialist** **Cardiologist** **Nephrologist** **(circle all that apply)**

<u>Please list the names of any Pain Specialist, Cardiologist or Nephrologist Treating You:</u>

NAME: ___________________________________ **Primary Care Doctor:** _________________________________

Dominant Hand: Right Left

Are You Pregnant: Yes No Not Applicable

Tobacco Use: Every Day Some Days Former Smoker Never Smoked

If A Smoker, Are You Interested In Quitting? Yes No

Alcohol Use: Daily Occasionally Never

Exercise: Daily Occasionally Never

Employment: Full Time Part Time Retired Student Unemployed

Marital Status: Single Married Divorced Widow/er

Have You Had A Flu Shot In The Last 6 Months? **Yes** **No**

Have You Had A Pneumonia Shot In The Last 6 Months? **Yes** **No**

Do You Have Any Advance Directives or An Advanced Care Plan? **Yes** **No**

If Yes, Who Have You Named As Your Surrogate Decision Maker? _____________________________

LIST MEDICATIONS YOU'RE CURRENTLY TAKING:		**LIST ANY SURGERIES YOU'VE HAD & INCLUDE YEAR DONE:**
1. _______________________________________ 2. _______________________________________ 3. _______________________________________ 4. _______________________________________ 5. _______________________________________ 6. ______________________________________ 7. ______________________________________ *If you have a list of medications already prepared, we will gladly make a copy		1. _______________________________________ 2. _______________________________________ 3. _______________________________________ 4. _______________________________________ 5. _______________________________________ 6. _______________________________________ 7. _______________________________________

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