

Patient Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_

### Medical Condition History

Please circle any of the following conditions you have had in the past or present. If you are unsure, please ask a staff member to assist you in filling out this form. You may circle more than one condition.

Alcoholism  
Anxiety  
Asthma  
Arthritis-rheumatoid  
Arthritis-osteo, degenerative  
Blood Clot Yr \_\_\_\_\_  
Blood Transfusion Yr \_\_\_\_\_  
Bone Infection  
Bowel disease

Cancer (specify) \_\_\_\_\_  
Congestive Heart Failure  
COPD  
(chronic obstructive pulmonary disease)  
Depression  
Diabetes  
Elevated Cholesterol  
Fibromyalgia  
Gerd/acid reflux

Gout  
Heart Attack Yr \_\_\_\_\_  
Heart Disease  
Hepatitis – Liver Disorder  
High Blood Pressure  
Hypothyroidism  
Irregular heart rate  
Kidney Disease  
Liver Disorder-Cirrhosis

Lung Disease  
Osteopenia/Osteoporosis  
Parkinson's  
Stroke  
Ulcer Disease  
Other (specify all other)  
\_\_\_\_\_  
\_\_\_\_\_

### Review of Systems

Please circle all problems you currently experience. You may circle more than one answer for each category.

**General:**  
recent weight gain  
recent weight loss  
appetite change  
difficulty sleeping

**Cardiovascular:**  
chest pain  
heart attack  
palpitations  
(irregular heart beat)  
edema (leg swelling)  
leg cramps w/walking

**Hematopoietic / Lymphatic:**  
low blood counts  
lymph node enlargement  
bleeding problems  
frequent infections

**Gastrointestinal:**  
heartburn / indigestion  
difficulty swallowing  
stomach pains  
ulcers  
nausea / vomiting  
diarrhea  
hemorrhoids  
rectal bleeding  
black bowel movements  
change in bowel habits  
constipation  
frequent laxative use  
jaundice or hepatitis  
liver trouble  
gallbladder problems

**Psychiatric:**  
anxious feelings  
depressive feelings  
seen by a psychiatrist

**Genitourinary:**  
burning on urination  
frequency of urination  
difficulty starting urine  
wetting pants or bed  
bloody urine

**Respiratory:**  
shortness of breath  
cough  
sputum  
bronchitis  
night sweats

**Musculoskeletal:**  
joint pain  
joint swelling or warmth  
joint stiffness  
muscle pain  
weakness  
back pain  
joint deformity

**Neurologic:**  
headaches  
dizziness  
blackouts  
numbness and tingling  
paralysis  
convulsions / seizures  
coordination trouble

Please explain any items circled \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*In order to insure proper and comprehensive care, you must follow-up with your primary care physician for any and all medical problems and concerns circled here.*

Do you take, or have you taken, blood thinners (i.e., Coumadin)?      yes      no

Do you take, or have you taken, steroids (i.e., prednisone, cortisone)?      yes      no

Have you had anesthesia before?      no      yes  
 general     local     spinal      Problems: \_\_\_\_\_

In case of emergency, contact:  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Relation: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ City: \_\_\_\_\_

Phone number of Medical Doctor: \_\_\_\_\_

Please initial to indicate you have completed this form: \_\_\_\_\_

Patient: please complete this side only.