Past Medical History

The Patient is positive for or has had a history of:

Heart:

- □ High blood pressure
- □ High cholesterol
- □ Chest pain with 2 flights of stairs
- □ Shortness of breath with 2 flights of stairs
- □ Cardiac testing or seen a cardiologist within the past 5 years (Stress test, ECHO)
  - □ Was told results were abnormal
- □ Irregular heart beat or murmur
- □ Heart attack
- □ Heart failure
- □ Sleeps with 2 or more pillows due to shortness of breath when laying flat
- □ Pacemaker or defibrillator
- □ Other Cardiac Conditions: _____

Lung:

- □ Recent cough, cold or fever
- □ Asthma
- □ Emphysema/COPD
- □ Uses an inhaler
  - □ Daily
  - □ Few times per week
  - □ Few times per month
- □ Has had to go to the hospital for Asthma/COPD
  - □ Required a breathing tube
  - □ Required oral steroids (prednisone)
- □ PPD positive
  - □ Has been treated for TB
- □ Restrictive lung disease
- □ Obstructive sleep apnea
  - □ Uses CPAP or BIPAP at night
- □ Other Lung Problems: _____

Neurologic:

- □ Epilepsy/Seizures
- □ Migraines or frequent headaches
- □ History of Stroke or "mini stroke" (TIA)
  - □ Residual weakness, blindness, language problems
- □ Loss of consciousness or passing out
- □ Carotid Artery Stenosis
- □ Required neurologic testing (Carotid ultrasound, EMG, Head CT)
- □ Experiences numbness or weakness
  - □ Upper extremities
  - □ Lowe extremities
- □ Other Neurologic problems: _____

GI/Hepatic:

- □ Gastrointestinal reflux (GERD) or Heart Burn

- □ Symptoms Daily
- □ Well controlled

□ Difficulty swallowing
□ Bowel incontinence
□ Frequent constipation
□ Frequent diarrhea
□ Dark or bloody stool
□ AIDS/HIV
□ Hepatitis (current or in the past)

- □ A
- □ B
- □ C

□ Liver Disease

- □ Cirrhosis (□Alcoholic □Hepatitis related)
- □ Other: _____

Kidney/GU:

□ Urinary incontinence
□ Burning with urination
□ Frequent Urination
□ Bleeding with urination
□ Diabetes

- □ Insulin dependent
- □ Oral meds
- □ Diet controlled

□ Kidney Disease
□ Dialysis

Hematologic:

□ Has been told by doctor that they bleed easily or have bleeding disorder
□ Has had a blood clot

- □ Leg
- □ Arm
- □ Lung
- □ Required heparin or Coumadin (warfarin) treatment

Endocrine:

□ Thyroid problems

- □ Hypothyroid
- □ Hyperthyroid

□ Cancer – Type: _____

- □ Chemo
- □ Radiation
- □ Surgery

Musculoskeletal:

□ Arthritis- Type and joints affected: _____
□ Neck pain
□ Back pain
□ Gout

□ Calf cramp with walking
□ Fibromyalgia
□ rash

HEENT:

□ Hoarseness
□ Dentures or partials
□ Loose tooth(teeth)
□ Infected tooth(teeth)
□ Hearing aids
□ Vision problems (Retinal vein/artery occlusion, cataracts, glaucoma, blindness)

Psychiatric:

□ Anxiety
□ Depression
□ Bipolar Disorder

□ _____

Other medical condition(s) not mentioned above

Treatment History:

□ Orthopedic Surgeries:

1. Surgery: Date: Physician:
2. Surgery: Date: Physician:
3. Surgery: Date: Physician:

□ Spine Surgeries:

1. Surgery: Date: Physician:
2. Surgery: Date: Physician:
3. Surgery: Date: Physician:

□ Other Surgeries:

1. Surgery: Date: Physician:
2. Surgery: Date: Physician:
3. Surgery: Date: Physician:

Did you improve from your surgical procedure(s)?

Most recent surgery? Yes_____ No_____

□ **Have been told that there was trouble/difficulty with Anesthesia**:

□ Difficult Airway
□ Nausea/Vomiting
□ Allergic Reaction: _____

Procedures:

□ Injections:

1. Type: Date: Physician:
2. Type: Date: Physician:
3. Type: Date: Physician:

Alternate Treatment Modalities

□ Chiropractic Treatment:

_____ Visits, (*helpful/not helpful)*

□ Acupuncture Treatment:

1. Acupuncturist

_____ Visits, (*helpful/not helpful)*

□ Physical Therapy:

_____ Visits, (*helpful/not helpful)*

Family History

Has any family member (blood related) had any of the following? Please select each that apply:

□ Yes □ No Life-threatening reaction to anesthesia (malignant hyperthermia)?
□ Yes □ No Heart Attack before age 55?
□ Yes □ No Disabling back pain?
□ Yes □ No Arthritis?
□ Yes □ No Muscle or nerve disease? If so, what _____
□ Yes □ No Cancers? If so, what type _____
□ Yes □ No Any other disease which might affect your treatment? Please list: _____
_____

Social History

How much alcohol do you usually drink?

□ None
□ 1 to 2 drinks per week
□ 1 to 2 drinks per day
□ 3 to 5 drinks per day
□ more than 5 drinks per day

□ Yes □ No Have you been treated for drug or alcohol abuse? Please clarify: _____
_____
□ Yes □ No Do you use street drugs? If yes, what? _____
□ Yes □ No Have you been a cigarette smoker in the past 5 years?
□ Yes □ No Currently, do you smoke? If yes, how much per day? _____
How many years have you been smoking? _____

Are you: □ Single □ Separated □Married □Widowed □Divorced

Number of children, if any: _____

□ Yes □ No Is there any chance you are pregnant