Health History

Name:_____ **Date:**_____

Height: _____ **Weight:**_____ ☐ **Male** ☐ **Female**

Past Medical History

Please check below if you have, or have had, any of these medical conditions

☐ **NO PAST MEDICAL PROBLEMS**
☐ Acid Reflux
☐ Adverse reaction to anesthesia
Type of reaction_____
☐ Alzheimer's or significant memory loss
☐ Anemia
☐ Angina or chest pain
☐ Asthma
☐ Arterial fibrillation or erratic heartbeat
☐ Bladder problems
☐ Bleeding ulcers
☐ Blood clot
☐ Legs ☐ Lungs
☐ Cancer Type:_____
☐ Congestive heart failure
☐ Coronary artery disease
☐ Dental disease
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Epilepsy/Seizures
☐ Fibromyalgia
☐ Gout
☐ Hemophilia/Excessive bleeding
☐ Hepatitis
☐ High blood pressure/Hypertension
☐ High Cholesterol
☐ HIV or AIDS
☐ Infections _____
MRSA? ☐ Yes ☐ No
☐ Kidney Disease
☐ Osteoarthritis
☐ Osteoporosis
☐ Pneumonia
☐ Psychiatric Disorder
☐ Rheumatoid arthritis
☐ Sickle Cell
☐ Sleep apnea
☐ CPAP Machine
☐ Stroke (CVA)
☐ Thyroid disease
☐ Other not listed, explain
_____
_____

Surgical History

Please check below if you have, or have had, any of these medical conditions

☐ **NO PAST SURGERY**
☐ Abdominal surgery
Type of Surgery:_____
☐ Aneurysm
☐ Angioplasty/Stents
☐ Artery bypass of arm or leg
☐ Bone/Joint surgery
Type of surgery: _____
☐ Breast Surgery
Type of Surgery:_____
☐ Cartoid surgery
☐ Cervical spine surgery
☐ Colon surgery
☐ Coronary bypass (CABG)
☐ Gastric bypass surgery
☐ Heart valve replacement
☐ Hysterectomy
☐ Lumbar Spine Surgery
☐ Pacemaker/Defibrillator
☐ Prostate surgery
☐ Other not listed, explain
_____
_____