

Patient Name _____ Date _____

Birth Date _____ Physician _____ Phone _____

Under a Physician's Care Now? _____ What for? _____

Please answer the following questions by checking "yes" or "no" so that we may better assist you. If the answer is "yes", please explain!

Yes	No		Yes	No	
___	___	Asthma	___	___	Allergies to medicine (please list)
___	___	Anemia			_____
___	___	Arthritis			_____
___	___	Aids			_____
___	___	Bacterial Endocarditis	___	___	Allergies to anesthetic (explain)
___	___	Chemotherapy			_____
___	___	Diabetes			_____
___	___	Excessive Bleeding	___	___	Epilepsy or Seizures (explain)
___	___	Hepatitis			_____
___	___	HIV Positive			_____
___	___	High or Low Blood Pressure	___	___	Are you taking pain medication?
___	___	Heart Attack			What for (explain) _____
___	___	Heart Surgery			_____
___	___	Headaches			_____
___	___	Heart Murmur (Adult or Child)			_____
___	___	Immune Suppression	___	___	Does heart or valve disease limit
___	___	Joint Replacement			your daily activities (explain)
___	___	Latex Allergy			_____
___	___	Malignancies			_____
___	___	Mitral Valve Prolapse			Please list ALL medications you take
___	___	Nervous Problems			and what they are for
___	___	Organ Transplant			_____
___	___	Psychiatric Problems			_____
___	___	Radiation Treatments			_____
___	___	Sexually Transmitted Diseases			_____
___	___	Sinus Problems			_____
___	___	Stroke			_____
___	___	Do you use illegal drugs	___	___	Do you use tobacco products (what
___	___	Are you pregnant			kind and how much) _____
___	___	Are you trying to get pregnant			_____
___	___	Are you now or have you ever been treated for alcohol or drug abuse			
___	___	Are you currently suffering from severe health problems (explain)			_____
___	___	Have you ever been hospitalized (explain)			_____

Signed _____

Date _____