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.