

Please check below all that apply to you or a blood relative

	YOU	FAMILY MEMBER	LIST YOUR PRIOR SURGERIES
DIABETES—Type 1 2			
THYROID DISEASE			
HEART DISEASE			
CIRCULATION (PVD)			
HIGH BLOOD PRESSURE			
CHOLESTEROL			
STROKE			
LUNG OR ASTHMA			
ARTHRITIS			
CANCER			
SKIN DISORDERS			
LIVER/ KIDNEY ISSUES			
GOUT			
STOMACH OR G.I.			
HEPATITIS, HIV+, AIDS			

List Current Prescriptions Drugs below

List over the counter and supplements  
(such aspirin, vitamins, fish oil, etc.)


**Review of Systems: (✓ check all that apply to you)**

Awaken from sleep w/ difficulty breathing or coughing	Heart palpitations /Arrhythmia	
Back problems	Swelling of Ankles / Feet	
Chest pain	Hearing problems	
Circulatory problems	Respiratory problems	
Dizziness	Headaches	
Eye problems	Urinary frequency	

PRINT Name: \_\_\_\_\_ Date: \_\_\_\_\_

MA \_\_\_\_\_