

Patient name: _____

Please check all items that apply to your medical history:

<p>Lung Problems</p> <ul style="list-style-type: none"><input type="checkbox"/> Not Applicable<input type="checkbox"/> Asthma<input type="checkbox"/> Cough<input type="checkbox"/> Chronic bronchitis<input type="checkbox"/> COPD<input type="checkbox"/> Emphysema<input type="checkbox"/> Shortness of Breath<input type="checkbox"/> Tuberculosis <p>Have you ever been exposed to TB? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>	<p>Vision Problems</p> <ul style="list-style-type: none"><input type="checkbox"/> Not applicable<input type="checkbox"/> Blind <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye<input type="checkbox"/> Glaucoma<input type="checkbox"/> Cataracts <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye<input type="checkbox"/> Implants <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye<input type="checkbox"/> Glasses<input type="checkbox"/> other: _____ <p>Hearing Problems</p> <ul style="list-style-type: none"><input type="checkbox"/> Not Applicable<input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Right <input type="checkbox"/> Left<input type="checkbox"/> Hearing Aid<input type="checkbox"/> Other _____	<p>Urinary Problems</p> <ul style="list-style-type: none"><input type="checkbox"/> Not Applicable<input type="checkbox"/> Blood in urine<input type="checkbox"/> Kidney disease<input type="checkbox"/> Kidney stones<input type="checkbox"/> Urinary tract infections<input type="checkbox"/> Kidney dialysis<input type="checkbox"/> Fistula <input type="checkbox"/> Right arm <input type="checkbox"/> Left arm<input type="checkbox"/> Difficulty with urination<input type="checkbox"/> Leaking urine<ul style="list-style-type: none"><input type="checkbox"/> with exercise <input type="checkbox"/> all the time<input type="checkbox"/> Enlarged prostate<input type="checkbox"/> Other _____
<p>Heart Problems</p> <ul style="list-style-type: none"><input type="checkbox"/> Not Applicable<input type="checkbox"/> Aneurysm<input type="checkbox"/> Angina (chest pain)<input type="checkbox"/> Blood clots, phlebitis<input type="checkbox"/> Blood vessel disease<input type="checkbox"/> Circulation problems<input type="checkbox"/> Congestive heart failure<input type="checkbox"/> Heart attack: Year _____<input type="checkbox"/> High blood pressure<input type="checkbox"/> Irregular heart beat<input type="checkbox"/> Mitral valve prolapse<input type="checkbox"/> Rheumatic fever: Year _____<input type="checkbox"/> Sickle cell disease<input type="checkbox"/> Other _____	<p>Dentures _____</p> <p>Gland / Liver Problems</p> <ul style="list-style-type: none"><input type="checkbox"/> Not Applicable<input type="checkbox"/> Diabetes (sugar)<input type="checkbox"/> Low blood sugar<input type="checkbox"/> Thyroid<input type="checkbox"/> Cirrhosis<input type="checkbox"/> Hepatitis (yellow jaundice)	<p>Reproductive Problems</p> <ul style="list-style-type: none"><input type="checkbox"/> Not Applicable<input type="checkbox"/> Endometriosis<input type="checkbox"/> Menopause<input type="checkbox"/> Painful menstruation<input type="checkbox"/> Pelvic pain<input type="checkbox"/> Abnormal bleeding<input type="checkbox"/> Vaginal discharge or inflammation<input type="checkbox"/> Ovarian cysts<input type="checkbox"/> Hormone replacement<input type="checkbox"/> Sexual dysfunction<input type="checkbox"/> Other _____
<p>Muscle / Bone Problems</p> <ul style="list-style-type: none"><input type="checkbox"/> Not Applicable<input type="checkbox"/> Arthritis<input type="checkbox"/> Bone pain<input type="checkbox"/> Lupus<input type="checkbox"/> Osteoporosis<input type="checkbox"/> Prosthesis: <input type="checkbox"/> Arm <input type="checkbox"/> Leg<input type="checkbox"/> Myasthenia Gravis<input type="checkbox"/> Use assistive devices<input type="checkbox"/> Other _____	<p>Skin Problems</p> <ul style="list-style-type: none"><input type="checkbox"/> Not Applicable<input type="checkbox"/> Moles<input type="checkbox"/> Skin Cancer	<p>Is there any chance you could be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date of last menstrual period: _____</p>
<p>Nervous System Problems</p> <ul style="list-style-type: none"><input type="checkbox"/> Not Applicable<input type="checkbox"/> Migraine headaches<input type="checkbox"/> TIA <input type="checkbox"/> Stroke<input type="checkbox"/> Epilepsy/seizures<ul style="list-style-type: none">date of last one: _____<input type="checkbox"/> Multiple sclerosis<input type="checkbox"/> Tremors<input type="checkbox"/> Other _____	<p>Stomach / Bowel Problems</p> <ul style="list-style-type: none"><input type="checkbox"/> Not Applicable<input type="checkbox"/> Crohn's Disease<input type="checkbox"/> Ulcerative Colitis<input type="checkbox"/> Diverticulosis, Diverticulitis<input type="checkbox"/> Colon Polyps<input type="checkbox"/> Irritable bowel syndrome<input type="checkbox"/> Hemorrhoids<input type="checkbox"/> Constipation<input type="checkbox"/> Incontinence<input type="checkbox"/> Diarrhea<input type="checkbox"/> Esophageal varices (varicose veins)<input type="checkbox"/> Hiatal hernia, GERD, reflux<input type="checkbox"/> Inflammation of:<ul style="list-style-type: none"><input type="checkbox"/> Stomach <input type="checkbox"/> esophagus<input type="checkbox"/> Trouble swallowing<input type="checkbox"/> Esophageal narrowing<input type="checkbox"/> Barrett's esophagus<input type="checkbox"/> Ulcers<input type="checkbox"/> Bleeding<input type="checkbox"/> Other: _____	<p>Hematologic / Immunologic</p> <ul style="list-style-type: none"><input type="checkbox"/> Not Applicable<input type="checkbox"/> Anemia<input type="checkbox"/> Easily Bruised<input type="checkbox"/> Easily infected<input type="checkbox"/> Easily bleed <p>Psychiatric / Psychological</p> <ul style="list-style-type: none"><input type="checkbox"/> Not Applicable<input type="checkbox"/> History of confusion<input type="checkbox"/> Mental illness<input type="checkbox"/> Drug addition<input type="checkbox"/> Alcoholism<input type="checkbox"/> Other _____ <p>Diagnosis of Cancer</p> <p>What kind? _____</p>

