

LIST ALL SURGERIES: NONE Tonsils / Appendix / Gallbladder / Stent / Bypass / RT LT – Total Hip / RT LT – Total Knee
 Other Surgeries: _____

Previous Hospitalizations in the past 5 years: _____

Please circle YES or No to each inquiry.

PAST MEDICAL HISTORY: Have you ever been diagnosed BY A DOCTOR with any of the following:

<p>HEENT: Yes No Cataract Yes No Migraine Headaches</p> <p>Cardiovascular: Yes No Heart Attack Yes No Heart Disease Yes No Peripheral Vascular Disease Yes No HTN (High Blood Pressure) Yes No CHF (Congestive Heart Failure)</p> <p>Endocrine: Yes No Diabetes Yes No Thyroid Disorders</p> <p>GU: Yes No Kidney Infections Yes No Kidney Failure</p>	<p>GI: Yes No Gastric Ulcer Yes No Acid Reflux Yes No Hiatal Hernia</p> <p>Hematologic: Yes No Anemia Yes No Blood Transfusions Yes No DVT (Blood Clot) Yes No Hepatitis Yes No HIV</p> <p>Neuro: Yes No Seizures Yes No CVA (stroke) yr _____ Yes No Peripheral Neuropathy</p> <p>Neoplasm: Yes No Cancer _____</p>	<p>Musculoskeletal: Yes No Osteoarthritis Yes No Rheumatoid Arthritis Yes No Fibromyalgia Yes No Gout Yes No Osteoporosis Yes No Fractured Bones List Here _____</p> <p>Pulmonary: Yes No Chronic Obstructive Pulmonary Dz (COPD) Yes No Asthma Yes No Pneumonia</p> <p>OTHER _____</p>
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REVIEW OF SYMPTOMS: Are you CURRENTLY having any of the following symptoms:

<p>Systemic: Yes No Fever Yes No Weight loss Yes No Weight gain Yes No Fatigue</p> <p>HEENT: Yes No Headache</p> <p>Cardiac: Yes No Chest Pain Yes No Irregular Heartbeat Yes No Cold Hands or Feet Yes No Leg Pain with Exercise</p> <p>Endocrine: Yes No Temperature Intolerance Yes No Excessive Thirst</p>	<p>GI: Yes No Abdominal Pain Yes No Heartburn Yes No Trouble Swallowing</p> <p>GU: Yes No Urinary Loss of Control Yes No Pain with Urination Yes No Frequent Urination</p> <p>Hematologic: Yes No Bleeding Problems Yes No Easy Bruising Tendency</p> <p>Musculoskeletal: Yes No Night Cramps</p>	<p>Neuro: Yes No Difficulty Keeping Balance Yes No Memory Lapse or Loss Yes No Numbness Yes No Tingling</p> <p>Pulmonary: Yes No Shortness of Breath</p> <p>Psych: Yes No Feeling Depressed Yes No Anxiety</p> <p>Skin: Yes No Skin Rash Yes No Skin Redness</p>
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I UNDERSTAND THIS INFORMATION WILL BECOME A PART OF MY PERMANENT RECORD.

Signature: _____

Date: _____