PATIENT'S NAME________________________________ TODAY'S DATE____/____/_____

AGE________ HEIGHT___________ WEIGHT____________ DATE OF BIRTH_____/____/_____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

YES NO		YES NO		YES NO	
☐ ☐	SINUSITIS	☐ ☐	ASTHMA	☐ ☐	DIABETES
☐ ☐	RHEUMATIC FEVER	☐ ☐	EMPHYSEMA	☐ ☐	STROKE
☐ ☐	CANCER	☐ ☐	BRONCHITIS	☐ ☐	NERVOUS DISORDER
☐ ☐	RADIATION THERAPY	☐ ☐	TUBERCULOSIS	☐ ☐	SUBSTANCE ABUSE
☐ ☐	HEART ATTACK	☐ ☐	ULCER	☐ ☐	EMOTIONAL DISORDER
☐ ☐	ANGINA (CHEST PAIN)	☐ ☐	REFLUX	☐ ☐	BLEEDING DISORDER
☐ ☐	CHEST SURGERY	☐ ☐	LIVER DISEASE	☐ ☐	IMMUNE DISORDER
☐ ☐	HEART MURMUR (MVP)	☐ ☐	HEPATITIS	☐ ☐	PROSTHETIC JOINTS
☐ ☐	PACEMAKER	☐ ☐	KIDNEY DISEASE	☐ ☐	TEMPOROMANDIBULAR DISORDER
☐ ☐	ARRHYTHMIA (IRREG. PULSE)	☐ ☐	DIALYSIS	☐ ☐	EPILEPSY
☐ ☐	HIGH BLOOD PRESSURE	☐ ☐	THYROID DISEASE	☐ ☐	PREGNANT CURRENTLY

ALLERGY TO MEDICATIONS____

OTHER ALLERGIES ____

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS:

YES NO		YES NO		YES NO	
☐ ☐	NITROGLYCERINE	☐ ☐	BREATHING MEDICINE	☐ ☐	INSULIN
☐ ☐	BLOOD PRESSURE MEDICINE	☐ ☐	ASPIRIN (DAILY)	☐ ☐	STEROIDS
☐ ☐	PAIN MEDICINE	☐ ☐	BLOOD THINNER (COUMADIN)	☐ ☐	TRANQUILIZERS

LIST CURRENT MEDICATIONS AND DOSAGES:________________________________

____

____

YES NO	
☐ ☐	HAVE YOU EVER HAD SURGERY IN A HOSPITAL OR OUTPATIENT?
☐ ☐	HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS?
☐ ☐	DO YOU SMOKE?

REMARKS: ____

____

____

____

____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT SIGNED_______________________