Patient Name______________________________**Date of Birth**____________________**Date**__________

Current Occupation (ex. Bus driver, clerical):

☐ Disabled ☐ Unemployed ☐ Student
☐ Retired ☐ Other ______________________

Marital Status

☐ Married ☐ Single ☐ Divorced
☐ Separated ☐ Partner ☐ Widowed

Exercise

☐ Active But No Formal Exercise
☐ Never ☐ Rarely ☐ Daily
☐ Other ____________________

Tobacco Use ☐ Smoke ☐ Dip ☐ Vapor	☐ Never ☐ Current Every Day User ☐ Occasionally ☐ Former User
Alcohol	☐ Never ☐ Current Every Day User ☐ Occasionally ☐ Former
Illicit Drugs ☐ Marijuana ☐ Other ____________	☐ Never ☐ Current Every Day User ☐ Occasionally ☐ Former User

Immediate Family Medical History **(Please check all that apply and indicate family members affected.)**

Mother, Father, Maternal Grandparents, Paternal Grandparents, Siblings, Aunts, and Uncles

☐ Alzheimer's Disease	☐ Glaucoma	☐ Osteoporosis
☐ Anemia	☐ Heart Attack	☐ Oxygen Use
☐ Aneurysm	☐ Heart Disease	☐ Rheumatoid Arthritis
☐ Asthma	☐ Hepatitis	☐ Renal Failure
☐ Bi-Polar	☐ Hypercholesterolemia	☐ Schizophrenia
☐ Blood Clots	☐ Hypertension (HBP)	☐ Scoliosis
☐ Congestive Heart Failure	☐ Hypoglycemia	☐ Seizures
☐ COPD	☐ HIV Positive	☐ Sleep Apnea
☐ Coronary Artery Disease	☐ Immunocompromised	☐ Stroke
☐ Cystic Fibrosis	☐ Kidney Disease	☐ Tuberculosis (TB)
☐ Depression	☐ Kidney Failure	☐ Thyroid Disease
☐ Diabetes	☐ Liver Disease	☐ TIA
☐ Diverticulitis	☐ Lupus	☐ Vascular Disease
☐ Emphysema	☐ Migraines	
☐ Epilepsy	☐ Multiple Sclerosis	
☐ Fibromyalgia	☐ Neuropathy	☐ No History of Familial Disease

☐ Cancer: __________
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☐ Other:
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Medication Allergies: (Please list)

☐ No Medication Allergies

______________________ ______________________
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Current Daily Medication: (Please list)
Please include dosage and frequency

☐ No Daily Medications

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Patient's Past Surgical History (Please check or list all surgeries)

☐ Appendix	☐ Gallbladder	☐ Organ Transplant
☐ Back	☐ Gastric Bypass	☐ Pacemaker
☐ CABG	☐ Heart Stents	☐ Pain Pump
☐ Cancer	☐ Hysterectomy (Partial or Complete)	☐ Spinal Cord Stimulator
☐ C-Section	☐ Lobectomy	☐ Surgical Infection
☐ Defibrillator	☐ Neck	☐ No Previous Surgery
☐ Other: ______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
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______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Patient's Past & Current Medical History (Please check or list all health issues)

☐ Alzheimer's Disease	☐ Glaucoma	☐ Osteoporosis
☐ Anemia	☐ Heart Attack	☐ Oxygen Use
☐ Aneurysm	☐ Heart Disease	☐ Rheumatoid Arthritis
☐ Asthma	☐ Hepatitis	☐ Renal Failure
☐ Bi-Polar	☐ Hypercholesterolemia	☐ Schizophrenia
☐ Blood Clots	☐ Hypertension (HBP)	☐ Scoliosis
☐ Congestive Heart Failure	☐ Hypoglycemia	☐ Seizures
☐ COPD	☐ HIV Positive	☐ Sleep Apnea
☐ Coronary Artery Disease	☐ Immunocompromised	☐ Stroke
☐ Cystic Fibrosis	☐ Kidney Disease	☐ Tuberculosis (TB)
☐ Depression	☐ Kidney Failure	☐ Thyroid Disease
☐ Diabetes	☐ Liver Disease	☐ TIA
☐ Diverticulitis	☐ Lupus	☐ Vascular Disease
☐ Emphysema	☐ Migraines	
☐ Epilepsy	☐ Multiple Sclerosis	
☐ Fibromyalgia	☐ Neuropathy	☐ No History of Familial Disease

☐ Cancer: ____________

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☐ Other:

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(Continued from previous page) Current Daily Medications:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________