Today's Date _____ Name _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ ZIP Code _____ Email Address _____

Mobile Phone _____ Work Phone _____ Home Phone _____

Emergency Contact _____ Phone _____ Relation _____

MEDICAL HISTORY

Physician's Name _____ Phone _____ Date of Last Visit _____

Specialist's Name _____ Phone _____ Date of Last Visit _____

Have you ever had a blood transfusion Yes No If yes, give approximate dates _____

Please circle either Yes or No to indicate whether you have had or are experiencing any of the following:

BONE / JOINT PROBLEM

Osteopenia Yes No

Osteoporosis Yes No

Do you take a pill medication for osteoporosis Yes No

Are you receiving infusions for osteoporosis Yes No

Date of last infusion _____

Arthritis Yes No

Osteoarthritis Yes No

Rheumatoid Arthritis Yes No

Artificial Joints Yes No

ENDOCRINE PROBLEM

Diabetes Yes No

What is your A1c value _____

Thyroid problems Yes No

KIDNEY / LIVER PROBLEM

Kidney Disease Yes No

Are you on dialysis Yes No

Jaundice/Liver Condition Yes No

Hepatitis A B C

NEUROLOGIC / NERVE PROBLEM

Glaucoma Yes No

Neurologic Disorder Yes No

Condition: _____

Stroke Yes No

Date of stroke _____

HEART / BLOOD PRESSURE PROBLEM

Angina Yes No

Atrial Fibrillation Yes No

Artificial Heart Valve Yes No

Blood Disorder (Anemia, Factor V, Von Willebrand, etc.) Yes No

Condition: _____

Coronary Artery Disease Yes No

Damage from Rheumatic/Scarlet Fever Yes No

Heart Attack/Myocardia Infarction Yes No

Blood Pressure: HIGH LOW NORMAL

High/Elevated Cholesterol Yes No

Mitral Valve Prolapse Yes No

Pacemaker Yes No

RESPIRATORY PROBLEM

Asthma Yes No

COPD Yes No

Tuberculosis Yes No

Sleep Apnea Yes No

Do you use a Cpap or other sleep appliance Yes No

Former Smoker (cigarettes, cigars, marijuana, e-cig/vaping etc.) Yes No

Current Smoker Yes No

If so, which products _____

Do you use chewing tobacco/other smokeless products Yes No

OTHER MEDICAL CONDITIONS

Cancer Yes No

Type of cancer _____

Undergoing Chemo/Radiation Yes No

Anxiety, depression, or psychiatric care Yes No

Are you taking medication for anxiety/depression Yes No

Chemical Dependency Yes No

Are you undergoing treatment for chemical dependency Yes No

Herpes Yes No

Venereal Disease Yes No

HIV Positive Yes No

What is your viral load _____

What is your CD4 count _____

MEDICATION ALERTS

Are you taking a blood thinner Yes No

Are you taking Meloxicam Yes No

Are you taking Methotrexate (Otrexup/Rasuvo) Yes No

Why are you taking it _____

_____

Have you had long-term steroid use for a heart or inflammatory condition Yes No

WOMEN

Pregnant Yes No

Due Date _____

Nursing Yes No

☐ **No Known Drug Allergies - Check box if you have no allergies**

ALLERGIES (Check all applicable)

- ☐ Aspirin
- ☐ Benzodiazepines
- ☐ Codeine
- ☐ Iodine
- ☐ Hydrocodone
- ☐ Latex
- ☐ Local Anesthetic
- ☐ NSAIDS
- ☐ Penicillin/Amoxicillin
- ☐ Sulfa Drugs

Other _____

_____

_____

MEDICATIONS (you may also bring a list of medications to your appointment)

_____

_____

_____

_____

_____

Height _____ **Weight** _____

Local Pharmacy _____

Location _____

Phone _____

The information given today is correct to the best of my knowledge.

I also understand that it is my responsibility to inform the office of any changes.

Signature _____

OFFICE USE ONLY: ASA CLASS I II III IV DR/HYG: _____