

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, for what reason? _____
Please provide the name, address, and the telephone number of your physician.

2. Have you been a patient in the hospital during the past two years? Yes No
If yes, for what reason? _____

3. Have you taken any medicine or drugs during the past two years? If yes, please list: _____ Yes No

4. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any drugs or medicines? If yes, please list: _____ Yes No

5. Have you ever had excessive bleeding requiring special treatment? Yes No

6. Do you use any tobacco products? Yes No

7. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? Yes No

8. Do your ankles swell during the day? Yes No

9. Have you lost or gained more than 10 pounds in the last year? Yes No

10. Do you use more than 2 pillows to sleep? Yes No

11. Do you ever wake up from sleep short of breath? Yes No

12. Are you on a special diet? Yes No

13. Check any of the following which apply in either past or present:

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Valve Prolapse | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cortisone Medication |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Family History of Cardiovascular Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> X-Ray Cobalt Treatment |
| <input type="checkbox"/> Angina pectoris (chest pain) | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cancer or Tumors |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> HIV Positive (AIDS) |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Artificial Joint of Any Type | <input type="checkbox"/> Any Form of Eating Disorder | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Diet Medication: Name _____ | <input type="checkbox"/> Recreational Drug Use | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Drug Addiction/Alcoholism | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Any Form of Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Birth Control Medication |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Pregnant - Due Date _____ |

14. Do you have any disease, condition of problem not listed? If so, please list: _____ Yes No.

Date _____

Signature: _____