Past Medical History

Do you have a diagnosed bleeding or clotting disorder? Yes No

Do you have anemia or other blood disorder? Yes No

Have you ever had a blood transfusion? Yes No

Have you ever had hepatitis or other liver disease? Yes No

Have you ever been tested for HIV or AIDS infection? Yes No

Was the result positive or negative? _____

Have you ever had a heart attack, heart failure or angina? Yes No

Do you have a heart pacemaker? Yes No

Do you have an artificial or damaged heart valve? Yes No

Do you have a metal plate or artificial joint in your body? Yes No

Have you been advised to take antibiotics for routine dental work? Yes No

Have you ever had a major organ transplant (kidney, liver, heart, etc.)? Yes No

Have you ever been treated for tuberculosis? Yes No

Do you have kidney disease? Yes No

Have you had a seizure, convulsion, stroke or blackout in the past 5 years? Yes No

Do you have diabetes mellitus? Yes No

Have you had, or are you currently being treated for, any illness(es) not already noted above? Yes No

If yes, please list:_____

_____

Have you had any surgeries or hospitalizations not already noted above? Yes No

If yes, please list:_____

_____

Do any skin problems or other medical problems run in your family? Yes No

If yes, please list:_____

_____

For Females Only

At what age did your periods begin? _____Do you still have periods? _____

Are your periods regular? _____First day of last period _____

Are you pregnant now or could you possibly be pregnant? Yes No

Additional Review of Symptoms:

Do you currently have ____Headaches ____with visual disturbance ____ Dizziness ____Diarrhea

____Nausea and/or Vomiting ____joint pains ____unexplained wt gain or wt loss ____fever

____night sweats ____muscle weakness ____none of the above

If any of the above are present, are you currently under the care of a physician for these problems? Yes No

Social History:

Do you smoke cigarettes? Yes No Packs per week: _____ Alcohol drinks per week: _____

Do you live alone? Yes No Are you currently employed? Yes No Who is your current employer?

_____ What is your current occupation?_____

Signature of Person Completing Form: _____ Date: _____

Relationship to patient: ____ Self ____ Parent Other: _____

Reviewed, in its entirety, by Physician _____Date:_____