All information provided will be scanned into your electronic medical record. Please complete accurately.

Date_____ Referring Physician_____ Height_____ Weight_____

Name_____ DOB_____ Age_____

MEDICAL HISTORY: (Have you had any of the following conditions?)

Pneumonia	No	Yes	Kidney Disease	No	Yes
Heart Attack	No	Yes	Hearing Loss	No	Yes
Liver Failure	No	Yes	Hepatitis	No	Yes
Jaundice at Birth	No	Yes	Heart Murmur	No	Yes
Angina	No	Yes	Epilepsy/Seizures	No	Yes
Heart Failure	No	Yes	Migraine Headaches	No	Yes
Stroke	No	Yes	Arthritis	No	Yes
Diabetes	No	Yes	Bleeding Disorders	No	Yes
Connective Tissue Disease	No	Yes	Cancer	No	Yes
High Blood Pressure	No	Yes	Type of Cancer _____		
Neck: Neuritis or Sciatica	No	Yes	Nervous Breakdown or Disorder	No	Yes
Enlarged Thyroid/Goiter	No	Yes	Asthma	No	Yes
Anemia-Chronic/Current	No	Yes	Emphysema	No	Yes
HIV	No	Yes	Enlarged Lymph Glands of Neck	No	Yes
			Drug Abuse, Past or Present	No	Yes

Any other chronic conditions that are not listed? _____

_____

Please describe any question that was answered **YES** from the above:

_____

_____

FAMILY HISTORY: (Has any ***blood relative*** had any of the following? ☐ Unknown

			Who				Who
Cancer	No	Yes	_____	High Blood Pressure	No	Yes	_____
Tuberculosis	No	Yes	_____	Bleeding Problems	No	Yes	_____
Diabetes	No	Yes	_____	Hearing Loss	No	Yes	_____
Heart Trouble	No	Yes	_____	Malignant Hyperthermia	No	Yes	_____

SOCIAL HISTORY:

Alcoholic Beverages Never___ Barely___ Moderate___ Daily___

Caffeinated Beverages Never___ Barely___ Moderate___ Daily___

Tobacco: Cigarettes_____packs per day for ___years; Cigar___ Pipe___ Chewing Tobacco___ Snuff___

Prior Smoker ☐ No ☐ Yes Quit: ☐ Yes ☐ No How long ago? _____

Is the environment in which you work loud or noisy?	No	Yes
Have you ever been exposed to any loud or unusual noises?	No	Yes
Are you exposed to chemicals or have you been?	No	Yes
Have you been in the military?	No	Yes

CURRENT MEDICATIONS: (List ALL including over the counter, hormones, diet pills etc.)☐ None

_____

_____

_____

ALLERGIES: ☐ None

_____ _____

_____ _____

_____ _____

SURGERIES: (List ALL Surgeries and dates)☐ None

_____ _____

_____ _____

_____ _____

_____ _____

HOSPITALIZATIONS: (not including surgery)☐ None

_____

_____

DIFFICULTIES WITH ANESTHESIA? ☐ No ☐ Yes ☐ Never been under anesthesia

If yes, please explain:

_____