

PATIENT NAME: _____ HT: _____ WT: _____ BP: _____ / _____ P: _____ O2: _____

FAMILY HISTORY

<input type="checkbox"/>	ALZHEIMER'S DISEASE	FAMILY MEMBER: _____
<input type="checkbox"/>	ARTHRITIS	FAMILY MEMBER: _____
<input type="checkbox"/>	ASTHMA	FAMILY MEMBER: _____
<input type="checkbox"/>	BACK PROBLEM	FAMILY MEMBER: _____
<input type="checkbox"/>	BLOOD COAGULATION DISORDER	FAMILY MEMBER: _____
<input type="checkbox"/>	CEREBROVASCULAR ACCIDENT	FAMILY MEMBER: _____
<input type="checkbox"/>	CHRONIC OBSTRUCTIVE LUNG DISEASE	FAMILY MEMBER: _____
<input type="checkbox"/>	CORONARY ARTERIOSCLEROSIS	FAMILY MEMBER: _____
<input type="checkbox"/>	DEPRESSIVE DISORDER	FAMILY MEMBER: _____
<input type="checkbox"/>	DIABETES MELLITUS	FAMILY MEMBER: _____
<input type="checkbox"/>	DISORDER OF CARDIOVASCULAR SYSTEM	FAMILY MEMBER: _____
<input type="checkbox"/>	DISORDER OF LUNG	FAMILY MEMBER: _____
<input type="checkbox"/>	DISORDER OF MUSCULOSKELTAL SYSTEM	FAMILY MEMBER: _____
<input type="checkbox"/>	DISORDER OF THYROID GLAND	FAMILY MEMBER: _____
<input type="checkbox"/>	HEART DISEASE	FAMILY MEMBER: _____
<input type="checkbox"/>	HYPERCHOLESTEROLEMIA	FAMILY MEMBER: _____
<input type="checkbox"/>	HYPERTENSIVE DISORDER	FAMILY MEMBER: _____
<input type="checkbox"/>	KIDNEY DISEASE	FAMILY MEMBER: _____
<input type="checkbox"/>	MALIGNANT HYPERTHERMIA	FAMILY MEMBER: _____
<input type="checkbox"/>	MALIGNANT NEOPLASTIC DISEASE	FAMILY MEMBER: _____
<input type="checkbox"/>	MYOCARDIAL INFARCTION	FAMILY MEMBER: _____
<input type="checkbox"/>	OSTEOPOROSIS	FAMILY MEMBER: _____

SOCIAL HISTORY

SMOKING STATUS	<input type="checkbox"/> NEVER	<input type="checkbox"/> CURRENT	<input type="checkbox"/> FORMER
TOBACCO-YEARS OF USE	_____		
ARE YOU CURRENTLY EMPLOYED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
LIVE ALONE OR WITH OTHERS	<input type="checkbox"/> ALONE	<input type="checkbox"/> WITH OTHERS	
ABLE TO CARE FOR SELF	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
SMOKING - HOW MUCH	_____		
HAS SMOKED SINCE AGE:	_____		
CHEWING TOBACCO	<input type="checkbox"/> NONE	<input type="checkbox"/> 1/DAY	<input type="checkbox"/> 2-4/DAY <input type="checkbox"/> 5+/DAY
ALCOHOL INTAKE	<input type="checkbox"/> NONE	<input type="checkbox"/> OCCASIONAL	<input type="checkbox"/> MODERATE <input type="checkbox"/> HEAVY
CAFFEINE INTAKE	<input type="checkbox"/> NONE	<input type="checkbox"/> OCCASIONAL	<input type="checkbox"/> MODERATE <input type="checkbox"/> HEAVY
DIET	<input type="checkbox"/> REGULAR	<input type="checkbox"/> VEGETARIAN	<input type="checkbox"/> GLUTEN FREE
EXERCISE LEVEL	<input type="checkbox"/> NONE	<input type="checkbox"/> OCCASIONAL	<input type="checkbox"/> MODERATE <input type="checkbox"/> HEAVY
GENERAL STRESS LEVEL	<input type="checkbox"/> LOW	<input type="checkbox"/> MODERATE	<input type="checkbox"/> HIGH
SPORTING ACTIVITIES	_____		
HAND DOMINANCE	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	
WORK RELATED INJURY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
AUTO RELATED INJURY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

ALLERGIES: _____

<u>MEDICATIONS</u>	<u>DOSAGE</u>	<u>FREQUENCY</u>

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<u>SURGICAL HISTORY</u>	
<input type="checkbox"/>	AMPUTATION
<input type="checkbox"/>	ANKLE/FOOT SURGERY
<input type="checkbox"/>	APPENDECTOMY
<input type="checkbox"/>	ARTHROSCOPIC SURGERY
<input type="checkbox"/>	BACK SURGERY
<input type="checkbox"/>	CAESAREAN SECTION
<input type="checkbox"/>	CARDIOVASCULAR SURGERY
<input type="checkbox"/>	CARPAL TUNNEL SURGERY
<input type="checkbox"/>	ELBOW SURGERY
<input type="checkbox"/>	FOOT SURGERY
<input type="checkbox"/>	FRACTURE SURGERY
<input type="checkbox"/>	GALLBLADDER SURGERY
<input type="checkbox"/>	GASTROINTESTINAL SURGERY
<input type="checkbox"/>	GENERAL SURGERY
<input type="checkbox"/>	HAND SURGERY
<input type="checkbox"/>	HEAD / NECK SURGERY
<input type="checkbox"/>	HERNIA REPAIR
<input type="checkbox"/>	HIP SURGERY
<input type="checkbox"/>	HYSTERECTOMY
<input type="checkbox"/>	INTERVENTIONAL RADIOLOGY
<input type="checkbox"/>	JOINT REPLACEMENT
<input type="checkbox"/>	KNEE SURGERY
<input type="checkbox"/>	ORTHOPEDIC SURGERY
<input type="checkbox"/>	OTHER: _____
<input type="checkbox"/>	PLASTIC SURGERY
<input type="checkbox"/>	SHOULDER SURGERY
<input type="checkbox"/>	SPINE SURGERY
<input type="checkbox"/>	STENT
<input type="checkbox"/>	THYROID SURGERY
<input type="checkbox"/>	VASCULAR SURGERY
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____

<u>PAST MEDICAL HISTORY</u>	
<input type="checkbox"/>	AIDS/HIV
<input type="checkbox"/>	ANEMIA
<input type="checkbox"/>	ANESTHESIA COMPLICATIONS
<input type="checkbox"/>	ANXIETY DISORDER
<input type="checkbox"/>	ANXIETY/DEPRESSION
<input type="checkbox"/>	ARTHRITIS
<input type="checkbox"/>	ARTIFICIAL JOINTS
<input type="checkbox"/>	ASTHMA
<input type="checkbox"/>	BLEEDING DISORDER
<input type="checkbox"/>	BLOOD CLOT
<input type="checkbox"/>	BLOOD TRANSFUSION
<input type="checkbox"/>	COPD
<input type="checkbox"/>	CANCER
<input type="checkbox"/>	CORONARY ARTERY DISEASE
<input type="checkbox"/>	DEPRESSION
<input type="checkbox"/>	DIABETES
<input type="checkbox"/>	EPILEPSY/SEIZURES
<input type="checkbox"/>	FIBROMYALGIA
<input type="checkbox"/>	GOUT
<input type="checkbox"/>	HEPATITIS
<input type="checkbox"/>	HERNIA
<input type="checkbox"/>	HEAD INJURY/CONCUSSION
<input type="checkbox"/>	HEADACHES
<input type="checkbox"/>	HEART ATTACK
<input type="checkbox"/>	HEART DISEASE
<input type="checkbox"/>	HEART PROBLEMS
<input type="checkbox"/>	HIGH CHOLESTEROL
<input type="checkbox"/>	HYPERLIPIDEMIA
<input type="checkbox"/>	HYPERTENSION
<input type="checkbox"/>	KIDNEY DISEASE
<input type="checkbox"/>	LIVER DISEASE
<input type="checkbox"/>	LYME DISEASE
<input type="checkbox"/>	MIGRAINES
<input type="checkbox"/>	MULTIPLE SCLEROSIS
<input type="checkbox"/>	OSTEOPOROSIS
<input type="checkbox"/>	PACEMAKER
<input type="checkbox"/>	PERIPHERAL VASCULAR DISEASE
<input type="checkbox"/>	POLIO
<input type="checkbox"/>	PULMONARY EMBOLISM
<input type="checkbox"/>	RHEUMATOID ARTHRITIS
<input type="checkbox"/>	STROKE
<input type="checkbox"/>	THYROID DISEASE
<input type="checkbox"/>	TUBERCULOSIS
<input type="checkbox"/>	ULCERS