

Last Name, First Name, MI \_\_\_\_\_ Date Of Birth \_\_\_\_\_

**PAST MEDICAL HISTORY – circle all that apply**

**HEART**

Hypertension(High Blood Pressure)  
Hypercholesterolemia (High cholesterol)  
Coronary Artery Disease  
Heart Attack Year(s) – \_\_\_\_\_  
Coronary Artery Stenting-Year(s) \_\_\_\_\_  
Atrial Fibrillation  
Other Heart Arrhythmia(irregular Heartbeat)  
Pacemaker

**LUNGS**

COPD(Chronic Lung Disease)  
Bronchitis  
Emphysema  
Asthma  
Obstructive Sleep Apnea

**CIRCULATION**

Anemia  
Bleeding disorder  
Blood Clots  
DVT (Blood Clot in Leg)  
Pulmonary Embolism(blood clot in lung)

**GASTROINTESTINAL**

GERD/reflex  
Hepatitis – Type A B C Unknown  
Peptic Ulcer Disease

**EYE**

Glaucoma  
Cataracts

**ENDOCRINE**

Diabetes Type I  
Diabetes Type II  
Hypothyroidism(LOW thyroid hormone level)

**KIDNEY**

Chronic Kidney Disease

**CANCER**

Skin –  
BCC  
SCC  
Melanoma  
Unknown  
Multiple  
Other: \_\_\_\_\_

Other Cancer

Type: \_\_\_\_\_

Year Completed Treatment: \_\_\_\_\_

Surgery: Yes No

Radiation Therapy: Yes No

Chemotherapy: Yes No

Type: \_\_\_\_\_

Year Completed Treatment: \_\_\_\_\_

Surgery: Yes No

Radiation Therapy: Yes No

Chemotherapy: Yes No

Type: \_\_\_\_\_

Year Completed Treatment: \_\_\_\_\_

Surgery: Yes No

Radiation Therapy: Yes No

Chemotherapy: Yes No

**ENVIRONMENTAL ALLERGIES**

Previous Allergy Testing: Yes No

Previous Allergy Shots: Yes No

Sensitive to: Trees  
Grasses  
Weeds  
Molds  
Pollens  
Dogs  
Cats

**CHEMICAL DEPENDENCY**

Alcohol  
Drugs – Type \_\_\_\_\_

**INFECTIOUS DISEASE**

Rheumatic Fever  
HIV Disease

**NEUROLOGIC**

Seizure Disorder  
Stroke/TIA – Year(s) \_\_\_\_\_

**PSYCHIATRIC**

Depression  
Bipolar Disorder  
Other: \_\_\_\_\_

**OTHER MEDICAL CONDITIONS NOT LISTED**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

**NONE**