Name:_____ DOB:_____

PAST MEDICAL HISTORY

Please check all that apply

- ☐ Abnormal Bleeding
- ☐ Acid Reflux
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Arthritis (Rheumatoid/Osteoarthritis)
- ☐ Asthma
- ☐ Barrett's Esophagus
- ☐ Bleeding Ulcers
- ☐ Blood Clots
- ☐ Cancer _____
- ☐ Cirrhosis of the Liver
- ☐ Colitis
- ☐ Congestive Heart Failure
- ☐ COPD/Lung Disease
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Elevated Cholesterol
- ☐ Fatty Liver
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ History of Head Injury
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ Hypertension
- ☐ History of Suicide Attempts
- ☐ HIV/AIDS
- ☐ Irregular Heartbeat
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Migraines
- ☐ Mini Stroke/Stroke
- ☐ Neuropathy
- ☐ Osteopenia/Osteoporosis
- ☐ Pancreatitis
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Pneumonia
- ☐ Prostate Problems
- ☐ Restless Leg Syndrome
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sjogren's Syndrome
- ☐ Sleep Apnea
- ☐ Positive TB Skin Test/ History of TB
- ☐ Thyroid Disease (Under/Over Active)
- ☐ Urinary Tract Infections
- ☐ Vitamin B12 Deficiency
- ☐ Vitamin D Deficiency

SURGICAL HISTORY

(Please include biopsies, eye surgeries, stent placements, etc.)

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE