If **you** the patient have had any of the following conditions, **please circle if yes:**
Abnormal heart rhythm, high cholesterol or lipids, heart disease, chest pain, heart attack, high blood pressure, congestive heart failure, heart valve problems, vascular disease, lung or breathing problems, emphysema, asthma, pneumonia, sleep apnea, home oxygen use, tuberculosis, kidney problems, kidney failure, kidney stones, liver problems, hepatitis, jaundice, seizures, stroke, TIA, neuropathy, migraines, acid reflux or heartburn, stomach ulcers, hiatal hernia of the stomach, diabetes, thyroid disease, anemia, bleeding or clotting disorder, HIV or AIDS, depression, anxiety, bipolar disorder, panic attacks, schizophrenia, Other: _____

**List ALL of your current medications:**

**List ALL of your prior surgeries:**

To the best of my knowledge, the questions on this form have been accurately and completely answered. I understand that providing incorrect or incomplete information can be dangerous to my (or patients) health. It is my responsibility to inform my doctor of ANY changes in my medical history.

Patient Name: _____

Patient Signature: _____ Date: _____