



Have you had any of the following:

**YES NO**

- Anemia
- Angina (chest pain)
- High Blood Pressure
- Hardening of the Arteries
- Heart Attack: When? \_\_\_\_\_
- Pacemaker
- Stroke: When? \_\_\_\_\_
- Emphysema
- Tuberculosis
- Asthma
- Chronic Bronchitis

**YES NO**

- Pneumonia
- Sleep Apnea/Snoring
- Epilepsy/ Seizures
- Fainting Spells
- Anxiety disorder
- Rheumatic Fever
- Heartburn/ Reflux
- Hepatitis
- Jaundice
- Kidney Disease
- Cancer: Type: \_\_\_\_\_

Do you require oxygen to breathe comfortably?  No  Yes : Flow Rate: \_\_\_\_\_

Do you have any other conditions that require treatment? (Please describe) \_\_\_\_\_

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Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please list **ALL** medications you are taking, including non-prescription drugs and herbal products:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Date: \_\_\_\_\_ Information provided by: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_