Patient Name:

Check ○ any of the following you have, or have had problems with:

○ Heart ○ Asthma ○ Gout ○High Blood Pressure
○ Circulation ○ Stomach Ulcers ○ Tuberculosis ○Frequent Infections
○ Arthritis ○ Hormones ○ Rheumatic Fever ○Neurological Disorder
○ Kidneys ○ Anemia ○ Liver ○Intestines
○ Lungs ○ Bladder ○ Healing
○ Cancer ○ Skin ○ Unexpected Weight Loss

Do you have any artificial joints?
Hip Yes___ No ___
Knee Yes___ No ___
Other ______________

Do you have a Heart Valve Implant? Yes___ No ___

FAMILY HISTORY

Is there a family (blood relative) history of:
○Heart Disease
○Bleeding Disorder
○Neurological Disorder
○Stroke
○Bunions
○Hammertoes
○Flatfeet
○Circulation problems in feet

Do you smoke? No ____ previously smoked Yes____ No ___
Yes____ number of packs per day ___________

Do you drink alcohol or beer? Yes____ No ____
○Light usage 1-2 per week ○Moderate 1-2 per day ○Heavy, more then 2 daily

Employment: ○Sit at job ○Stand at job ○Stand & walks at job ○Retired

Signature ____Date ____________