## Medical History: (Please select all that apply and specify any other medical conditions)

- [ ] Atrial Fibrillation
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] History of Heart Attack
- [ ] Congenital Heart Disorder
- [ ] Asthma
- [ ] Sleep Apnea  
  Use of [ ] CPAP [ ] BiPAP
- [ ] Gastro Esophageal Reflux Disease (Acid Reflux)
- [ ] Arthritis
- [ ] Diabetes Mellitus
  - [ ] Type 1
  - [ ] Type 2  
  Controlled with [ ] Pills [ ] Insulin
- [ ] Stroke
- [ ] Fibromyalgia
- [ ] Anxiety
- [ ] Depression
- [ ] Chronic Kidney Disease
- [ ] COPD / Emphysema (Chronic Obstructive Pulmonary Disease)
- [ ] History of Heart Failure
- [ ] Cirrhosis of Liver
- [ ] History of Stomach Ulcer
- [ ] Osteoporosis
- [ ] History of Kidney Stone(s)
- [ ] Cancer
  - Type: __________________________
  - Treatment: __________________________
- [ ] AIDS
- [ ] History of DVT (Deep Vein Thrombosis)
- [ ] Systemic Lupus Erythematosus
- [ ] Menopause
  - Type: [ ] Natural [ ] Surgical
  - Quit Date: __________________________
- [ ] Congestive Heart Failure
- [ ] Heart Murmur
- [ ] Heart Valve Disorder
- [ ] History of Rheumatic Fever
- [ ] Vascular (vein) Disease
- [ ] Hypothyroidism
- [ ] Hyperthyroidism
- [ ] Neuropathy
- [ ] Seizure
- [ ] Bipolar Disorder
- [ ] Anemia
- [ ] End Stage Renal Disease
  - Dialysis Frequency: ______________
- [ ] Enlarged Prostate / BPH
- [ ] Gout
  - Last Episode Prescribing:  
    ______________________________
- [ ] History of Sudden death in mother, father, sister or brother < 65 years of age
  ______________________________
- [ ] HIV Posit
- [ ] HIV Positive
- [ ] History of PE (Pulmonary Embolism)
- [ ] Complication with Anesthesia
- [ ] History of Alcoholism
  - Quit Date: __________________________
- [ ] Blood Coagulation Disorder
- [ ] Gestational History:
  - [ ] Hypertension
  - [ ] Diabetes
  - [ ] Preeclampsia or Preterm labor < 37 weeks

## Social History: (Please select all that apply)

<table>
<thead>
<tr>
<th>Marital Status:</th>
<th>[ ] Single</th>
<th>[ ] Married</th>
<th>[ ] Divorced</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Legally Separated</td>
<td>[ ] Widow / Widower</td>
<td>[ ] Life Partner</td>
<td>[ ] Civil Union</td>
</tr>
<tr>
<td>[ ] Common Law Marriage</td>
<td>[ ] Unknown</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Children:** Number of Children: _________

**Who you live with:**
- [ ] Spouse
- [ ] Significant Other
- [ ] Children
  - [ ] Family
  - [ ] Caregiver
- [ ] Adopted Family
- [ ] Foster Family
- [ ] Friend(s)
- [ ] Animals
- [ ] No Animals
- [ ] None

**Domestic Violence:**
- [ ] Yes
- [ ] No

**Do you feel safe at home?**
- [ ] Yes
- [ ] No

**Recently felt controlled, threatened, or were physically hurt:**
- [ ] Yes
- [ ] No

**Alcohol Use:**
- [ ] Yes
- [ ] No

**Former Use:**
- [ ] Yes
- [ ] No

**Quit:** __________________________

**Frequency:**
- [ ] Do not drink
- [ ] 0-2 drinks per day
- [ ] 2+ drinks per day
- [ ] A few times a week
- [ ] A few times a month
- [ ] Occasionally
- [ ] Other

**Smoking Status:**
- Do you smoke? [ ] Yes or [ ] No

**Physical Activity:**
- [ ] Walking
- [ ] Running
- [ ] Bicycling
- [ ] Swimming
- [ ] Yoga
- [ ] Aerobics
- [ ] Weight Training
- [ ] Other: __________________________

**Frequency:**
- [ ] 1-2 Times per wk
- [ ] 3-4 Times per wk
- [ ] 5-6 Times per wk
- [ ] Daily
- [ ] Other: __________________________

**Duration:**
- [ ] < 15 min per day
- [ ] 15-30 min per day
- [ ] 30-45 min per day
- [ ] 45-60 min per day
- [ ] 60-90 min per day
- [ ] > 90 min per day
- [ ] Other: __________________________
Surgical History: (Please select all that apply)

- [ ] Abdominal Aortic Aneurysm (AAA) Repair
- [ ] Amputation
- [ ] Appendix Removal
- [ ] AV Fistula Shunt
  - [ ] Left  [ ] Right
- [ ] Back Surgery
- [ ] CABG/Heart Bypass Surgery:
  - [ ] x1  [ ] x2  [ ] x3  [ ] x4  [ ] x5  [ ] x6  [ ] x7
- [ ] Cardiac Ablation
- [ ] Cardiac Stent
  - How Many: ____________
- [ ] Cardioversion
- [ ] Carotid Endarterectomy
- [ ] Cataract
  - [ ] Left  [ ] Right  [ ] Both
- [ ] Colon Surgery
- [ ] Coronary Angioplasty
- [ ] Defibrillator
  - Brand: ________________
- [ ] Gall Bladder Surgery
- [ ] Heart Catheterization
- [ ] Heart Surgery
  - Type: ________________
- [ ] Hernia Repair
  - [ ] Hiatal
  - [ ] Inguinal
  - [ ] Ventral
  - [ ] Umbilical
- [ ] Hip Replacement
  - [ ] Left  [ ] Right  [ ] Both
- [ ] Joint Surgery
  - Type: ________________
- [ ] Kidney Removal
  - [ ] Left  [ ] Right
- [ ] Kidney Stone Removal
- [ ] Kidney Transplant
  - [ ] Left  [ ] Right
- [ ] Knee Replacement
  - [ ] Left  [ ] Right  [ ] Both
- [ ] Loop Recorder
- [ ] Neck Surgery
- [ ] Pacemaker
  - Brand: ________________
- [ ] Portacath
- [ ] Tendon Surgery
  - Type: ________________

Other surgeries not mentioned above: ________________________________________________________________

Allergies: Please list your allergies with the type of reaction you experienced or select “None”

[ ] None

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Severity</th>
<th>Reaction</th>
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</thead>
<tbody>
<tr>
<td>_______________________</td>
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</table>

Medication List: Please list your medications and supplements or provide us with a list. If you do not take any medication, please select “None”

[ ] None

- [ ] Patient provided current medication list

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
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<tbody>
<tr>
<td>_________________________</td>
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Other Conditions: ________________________________________________________________

________________________________________ Date: ______/______/______

Patient Signature: X __________________________________________