

Chart#: \_\_\_\_\_ Referring Dr.: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Next Dr.'s Appt: \_\_\_\_\_

Please list prescription medications you are taking: \_\_\_\_\_

Allergic to any medications? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list: \_\_\_\_\_

Are you diabetic? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you take insulin? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had surgery? Yes \_\_\_\_\_ No \_\_\_\_\_ When: \_\_\_\_\_

If yes please list: \_\_\_\_\_

Do you have high blood pressure? Yes \_\_\_\_\_ No \_\_\_\_\_ What are yor numbers? \_\_\_\_/\_\_\_\_

Do you have a heart condition? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a pacemaker? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had a blood clot/phlebitis ? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Are you currently ( or in the past) received treatment for cancer? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when \_\_\_\_\_

Any other health problems? \_\_\_\_\_

FEMALES ONLY: Are you /could you be pregnant ? Yes \_\_\_\_\_ NO \_\_\_\_\_

Patient /Legal Guardian Signature: \_\_\_\_\_