Personal Medical History *(Please Print)*

Name: Height: Weight:

Do you have, or had:	Yes	Family History	Related surgeries/complications?
Anemia			
Angina			
Asthma			
Bleeding Disorders			Type:
Bone Injury/Fracture			Body Part(s):
Cancer			Type(s):
Congestive Heart Failure			
Chronic Pain			
Diabetes			Type I:___ Type II:___
Drug/Alcohol Abuse			How often?: How long?:
Emphysema			
Epilepsy/seizures			
Gout			
Heart Arrhythmia or Murmur			Type:
Heart Disease			
Heart Stents			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Joint Problems			Body Part(s):
Kidney Disease			
Ligament/Tendon Injury			Body Part(s):
Liver Disease			
Lupus			
Lyme Disease			
Migraine Headaches			
Nerve Problems			Type(s):
Rheumatologic Disease			Type(s):
Sickle Cell Anemia			
Thyroid disorders			
Tuberculosis			
Other:			

List any medications you are allergic to, and your reaction:_____

Do you smoke?: Yes:_____ No:_____

If yes, how many packs per day?:_____For how many years have you smoked?_____

Are you allergic to latex?: Yes:_____ No:_____

If yes, what is the reaction?: Itching_____ Swelling_____ Hives_____ Anaphylaxis_____ Other:_____

List any medications you are currently taking:_____