### Personal and Medical Information

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<th>Condition</th>
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<td>High Blood Pressure</td>
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<td>Heart Disease</td>
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<td>High Cholesterol</td>
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<td>Kidney Disease</td>
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<td>Asthma</td>
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<td>Emphysema</td>
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<td>Cancer</td>
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<td>Anemia</td>
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<td>Diabetes</td>
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<td>Stroke</td>
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<td>Blood Clots</td>
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List any other medical diagnosis you have:

Have you been hospitalized for any significant injury or illness: ☐ Yes ☐ No

If yes list reason and dates:

If you are currently taking any prescription medicine, over-the-counter medicine, vitamins, herbs, nutritional supplements or birth control pills, please list the medication name, dosage and frequency taken below:

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 

Are you ALLERGIC to any medication, food or latex? ☐ Yes ☐ No

If yes what? Type of reaction:

Do you smoke? ☐ Yes ☐ No

If yes how much? How many years?

Did you ever smoke? ☐ Yes ☐ No

If yes, quit date? # Yrs. smoked?

Do you drink alcohol? ☐ Yes ☐ No

If yes how much? How many years?

Do you drink caffeinated drinks ☐ Yes ☐ No

If yes how much? Type: ☐ Coffee ☐ Tea ☐ Soda

Do you normally eat a balanced diet ☐ Yes ☐ No

Meals per day? Snacks per day?

Do you exercise on a regular basis? ☐ Yes ☐ No

Days per week?

Type of:

Do you live with others? ☐ Yes ☐ No

If yes who? ☐ Husband ☐ Wife ☐ Partner ☐ Children ☐ Single ☐ Roommate(s)
Are you employed?  □ Yes  □ No  If yes:  □ Full time  □ Part time  □ Retired

Have you had any of the following immunizations? If yes, include last year you had the immunization.

<table>
<thead>
<tr>
<th>Year</th>
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<tbody>
<tr>
<td>Tetanus</td>
<td>Flu Shot</td>
<td>Pneumococcal</td>
<td>Hepatitis B</td>
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</table>

Have you had any of the following tests? If yes, include last year you had the test.

<table>
<thead>
<tr>
<th>Year</th>
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<tbody>
<tr>
<td>EKG</td>
<td>Stress Test</td>
<td>Colonoscopy</td>
<td>Mammogram</td>
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Check any symptoms and or conditions listed below that you have experienced in the past 12 months:

**Vision:**  □ Change in far vision  □ Change in near vision  □ Blurred Vision

**Hearing:**  □ Ear pain  □ Loss of Hearing  □ Ringing in Ears

**Musculoskeletal**  □ Joint Pain  □ Joint Stiffness  □ Muscle weakness  □ Unsteady Walking

**Cardiovascular**  □ Chest pain  □ Palpitations

**Respiratory:**  □ Shortness of breath  □ Wheezing  □ Coughing  □ Coughing up blood

**Circulatory:**  □ Swelling of the Hands/Feet  □ Leg Cramps with walking

**Endocrine:**  □ Excessive thirst  □ Frequent urination  □ Unintentional Weight Change > 5 lb.

**Gastrointestinal**  □ Diarrhea  □ Constipation  □ Blood in stools  □ Heartburn

**Neurological**  □ Headaches  □ Numbness or tingling in extremities

**Emotional:**  □ Depression  □ Anxiety

I attest that this information is correct to the best of my knowledge.

X

Patients Signature:  Date:

Reviewed by  Clinician’s signature:  Date: