THE FOLLOWING DOCUUMENTATION MUST BE AVAILABLE AT THE TIME OF BOOKING

PATIENT TO COMPLETE:

Patient Name: ______________________________ Date Of Birth: ______________ Sex: ____________

(2) Phone numbers: 1- (_______) _________ ______ Secondry contact: 2- (_______) ________ __________

Your Email: _________________________________ Primary Care Physician: _________________________

Current/Primary Complaint(s): ____

____

MEDICAL HISTORY: Please answer the following questions:

- Do you have sleep apnea, use CPAP or BiPAP? ☐Yes ☐No
- Do you become short of breath or develop chest pain when climbing two flights of stair? ☐Yes ☐No
- Do you have high bloof pressure that requires three or more medications to manage? ☐Yes ☐No
- Have you ever had blood clots, strokem carotid artery blockagem or TIAs (mini strokes) ☐Yes ☐No
- Are you currently taking blood thinners, such as Coumadin, Plavix, etx? ☐Yes ☐No
- Do you have history of liver disease or chronic cirrhosis? ☐Yes ☐No
- In the past two years have you required prolonged treatment with steroids? ☐Yes ☐No
- Do you have diabetes that requires insulin treatment? ☐Yes ☐No
- Do you have problems with excessive bleeding after surgical or dental procedures? ☐Yes ☐No
- Are you/the patient or do you/the patient believe you/the patient might be pregnant? ☐Yes ☐No
- Do you have kidney problems (except for kidney stones or recurrent infections) that require treatment by a kidney specialist or are you on dialysis? ☐Yes ☐No

IMPLANTABLE DEVICE(S): ☐No ☐Yes, Indicate type of device(s):

☐ Pacemaker/Defibrillator Year:	☐ Cardiac Stent Year:	☐ Ventricular Assist Device Year:	☐ Insulin Pump Year:	☐ Other

SURGICAL HISTORY: ☐No ☐Yes, list surgeries:

Year:	Type of Surgery/Procedure	Describe any Anesthesia Compliation *(other than Nausea or Vomiting):*

SOCIAL HISTORY (Please circle) smoking, alcohol, drug use (Other please specify)

Smoking	Alcohol	Drug Use	Other

ALLERGIES: ☐No ☐Yes (Please specify)

Allergies:

EXCERCISE TOLERANCE:

I get shortness of breath walking around the block ☐No ☐Yes

MEDICATIONS: ☐ Not taking medication
☐ Yes: Please complete list of all medications prescribed include over the counter or when needed

Medication	Dose	Frequency	Medication	Dose	Frequency
1			6		
2			7		
3			8		
4			9		
5			10		