Have you **ever** been told you have any of the following health conditions? Please check yes even if you are currently on medication to control the condition.

**Past Medical History**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Explain |
| Anxiety / Depression |  |  |  |
| Arthritis |  |  |  |
| Asthma |  |  |  |
| Cancer (Type) |  |  |  |
| COPD |  |  |  |
| Ear / Nose / Throat |  |  |  |
| Elevated Cholesterol |  |  |  |
| Diabetes (with or without insulin) |  |  |  |
| GERD |  |  |  |
| Gynecological / Urinary Conditions |  |  |  |
| Hepatitis |  |  |  |
| High Blood Pressure |  |  |  |
| HIV / AIDS |  |  |  |
| Hypothyroidism / Hyperthyroid |  |  |  |
| Immune Disorder |  |  |  |
| Kidney Stones / Kidney Disease |  |  |  |
| Lupus |  |  |  |
| Lyme Disease |  |  |  |
| Migraines / Cluster Headaches |  |  |  |
| Skin Disorder |  |  |  |

Any other conditions / general surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list all current prescription and over-the-counter medications you take: NONE

Are you **allergic** to any medications or latex? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoking (Circle One): Never / Previous / Current Do you drink alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# REVIEWED BY DR. LOPATYNSKY / DR. SARKAR / DR.BARBATO / DR. GUTMAN

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_