PREVIOUS SURGERIES/DATES: 1) _____ 3) _____

2) _____ 4) _____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING? *(Place ☑ by applicable items)*

- ☐ Headache
- ☐ Earache
- ☐ Sore throat
- ☐ Sinus trouble
- ☐ Hoarseness
- ☐ Eye problems
- ☐ Chest pain/pressure
- ☐ Short of breath
- ☐ Sleep w/ head elevated
- ☐ Swollen ankles
- ☐ Rapid or irregular pulse
- ☐ Cough Abdominal pain
- ☐ Nausea/Vomiting
- ☐ Trouble swallowing
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Weight gain
- ☐ Weight loss
- ☐ Urine burns
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Difficulty w/ stream
- ☐ Urinary incontinence
- ☐ Excessive thirst
- ☐ Excessive appetite
- ☐ Double vision
- ☐ Trouble walking
- ☐ Trouble talking
- ☐ Numbness anywhere
- ☐ Weakness
- ☐ Dizzy spells
- ☐ Blackouts
- ☐ Joint pain
- ☐ Back pain
- ☐ Muscle aches
- ☐ Abnormal bruising
- ☐ Abnormal bleeding

YOUR PAST HISTORY Please ☑ *if you have ever had:*

- ☐ Heart rhythm problem
- ☐ Heart attack
- ☐ Heart failure
- ☐ Angina
- ☐ High blood pressure
- ☐ Blood clots in legs
- ☐ Blood clots in lungs
- ☐ Heart valve problem
- ☐ TB
- ☐ Emphysema
- ☐ Asthma
- ☐ Anemia
- ☐ Ulcer
- ☐ Hepatitis
- ☐ Head injury
- ☐ Glaucoma
- ☐ Pancreatitis
- ☐ Gallbladder trouble
- ☐ Cancer
- ☐ Colitis
- ☐ Kidney trouble
- ☐ Prostate trouble
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Diabetes
- ☐ Arthritis
- ☐ Lupus
- ☐ Abnormal bleeding
- ☐ Diverticulitis

YOUR CURRENT MEDICINES, INCLUDING DOSAGE AND FREQUENCY: *(May attach a list)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

WHAT DRUG OR ENVIRONMENTAL ALLERGIES DO YOU HAVE? _____

SOCIAL HISTORY: *(Please Check All That Apply)*

Tobacco Use

- ☐ Never
- ☐ Quit–*When*_____
- ☐ Cigarettes–*Pack/Day*____
- ☐ Pipe
- ☐ Cigars
- ☐ Chewing Tobacco

*How many years?*____

Alcohol Use

- ☐ None
- ☐ Socially
- ☐ Daily

Drug Use

- ☐ None
- ☐ Marijuana
- ☐ Amphetamines
- ☐ Other

Caffeine Use

- ☐ None
- ☐ Occasional
- ☐ Daily

Exercise

- ☐ None
- ☐ 1 - 2x week
- ☐ 3 - 4x week
- ☐ 5 - 7x week

FAMILY HISTORY: Does any direct relative have:

- ☐ Asthma
- ☐ Allergic condition
- ☐ Lung cancer
- ☐ TB
- ☐ Heart problem before age 60
- ☐ Emphysema
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Sleep disorders

PHARMACY: _____ Address: _____ Phone: _____ Fax: _____

IF YOU USE OXYGEN OR CPAP PLEASE CHECK THE COMPANY WHO SUPPLIES IT:

- ☐ Lincare
- ☐ Baycare
- ☐ Apria
- ☐ Rotech
- ☐ American Home Paitient
- ☐ Sarasota Oxygen & Cpap
- ☐ Aero Care
- ☐ Cpap.com
- ☐ Other: _____

Print: **Date:**

Sign: _____