

14) Please CHECK any of the following MEDICAL PROBLEMS you have now or have had in the past. List any others.

HEART
_____ High Blood Pressure
_____ Angina
_____ Heart Attack
_____ Irregular Heart Beat
_____ Heart Murmur
_____ Pacemaker

STOMACH, BOWEL, LIVER
_____ Ulcers
_____ Colitis
_____ Diverticulitis
_____ Irritable Bowels/
Crohn's Disease
_____ Hepatitis

EYES
_____ Glaucoma
EARS
_____ Hearing Impaired

LUNGS
_____ Sarcoidosis
_____ Emphysema
_____ Tuberculosis

ARTHRITIS
_____ Rheumatoid
_____ Osteoarthritis
_____ Psoriatic
_____ Lupus

ALLERGIES
_____ Asthma
_____ Hayfever
_____ Sinus Problems
_____ Hives

NEUROLOGIC
_____ Migraine Headache
_____ Seizures/Epilepsy
_____ Stroke

BONE/JOINT IMPLANTS
_____ Artificial Knee
_____ Artificial Hip
_____ Metal Pins
_____ Other, Specify _____

BLOOD
_____ Bleeding Problems
_____ Anemia

METABOLIC
_____ Diabetes
_____ Thyroid Problems
_____ Other, Specify _____

GYNECOLOGICAL
_____ Irregular Menstrual
Cycles

CANCER
_____ Location
Treatment:
_____ Surgery
_____ Radiation
_____ Chemotherapy
Year of treatment _____

KIDNEYS
_____ Kidney Disease
_____ Polycystic Kidneys

MENTAL HEALTH
_____ Counseling
_____ Medication

15) How much alcohol do you drink? _____

16) OTHER MEDICAL CONDITIONS:

17) List any SURGERY you have had within the past year:

[] No surgery.

Thank you for your cooperation in completing the above questionnaire.

Signature of Patient/Guardian

Date

For office use:

The above PATIENT PROFILE was reviewed with the patient and/or parent/guardian

by _____