Medical Information

Emergency Contact:	Relationship:	Phone:
Primary Physician:	Last Visit Date:	Phone:
Specialist Physician(s) [Cardiologist, etc.]:	Last Visit Date(s):	Phone:

1. Do you suffer from, or have you been treated for any of the following? (Check any that are applicable.)

Cardiovascular		**Nervous System**		**Respiratory**		**Endocrine**	
CAD (angina, heart attack)		Seizures / Epilepsy		COPD		Thyroid Disorders	
Heart Failure (weak heart)		Depression or Panic Attacks		Emphysema		Diabetes Mellitus	
High Blood Pressure		Psychosis or Mania		Chronic bronchitis		Immune Disorder	
Low Blood Pressure		Multiple Sclerosis		Asthma		Pregnant	
Arrhythmias (irregular beat)		Headaches/Migraine		Sinus/Hay Fever		Breast-feeding	
Congenital heart defect		Substance Abuse		Obstructive Sleep		**Excretory**	
Valve Disease or Murmur		Alzheimer's/other Dementia		**Miscellaneous**		Liver Disorder	
Artificial Heart Valve		Physical/Mental Impairment		Cancer		Kidney Disorder	
Endocarditis (Heart Infection)		**Infections**		Joint Replacements		Bladder Disorder	
Stroke or TIA		Hepatitis		Organ Transplant		Ulcers or GERD	
Bleeding Problems		HIV/AIDS		Glaucoma		Intestinal Problems	
Blood Cell Disorders		Tuberculosis					

2. Please list any medical problems you have that are not listed in this table:

3. Please list ALL medications you are taking, including non-prescription products:

4. Please list any allergies to medications, foods, or any other substances:

5. Have you ever received a local anesthetic? Y/N A general anesthetic? Y/N Any problems? Y/N

For Office Use Only: Baselines: BP _____ HR _____ SpO_2_____ ASA Status: _____

Medical Condition	**Medication(s)**	**Medical Condition**	**Medication(s)**

Notes/Clarifications: