



**8. IMMUNOLOGY**

Frequent infections                      **NO**    **YES**  
Organ transplant                        **NO**    **YES**

**9. MUSCULOSKELETAL**

Fibromyalgia                              **NO**    **YES**  
Arthritis                                    **NO**    **YES**  
Other joint/muscle problems        **NO**    **YES**

**10. NEPHROLOGY**

Are you on dialysis?                    **NO**    **YES**  
    If yes, what days do you go? \_\_\_\_\_

Chronic Kidney Disease                **NO**    **YES**

**11. NEUROLOGY**

Have you ever had a stroke    **NO**    **YES**  
Seizures                                    **NO**    **YES**

**12. ONCOLOGY**

Cancer                                      **NO**    **YES**

**13. PULMONARY**

Lung Disease                              **NO**    **YES**  
Asthma                                      **NO**    **YES**  
Emphysema                                **NO**    **YES**

**14. PSYCHIATRIC**

Depression                                **NO**    **YES**  
Schizophrenia                            **NO**    **YES**  
Other mental illness                    **NO**    **YES**

**15. VASCULAR**

Poor Circulation                        **NO**    **YES**  
Pain in legs with walking            **NO**    **YES**  
Non healing ulcer on legs  
or feet                                      **NO**    **YES**

**16. LYMPHATICS**

Swelling or edema                      **NO**    **YES**  
Varicose Veins                            **NO**    **YES**

**SURGICAL HISTORY**

Have you ever had surgery? \_\_\_\_\_ No \_\_\_\_\_ Yes If yes, describe.

What type of surgery?	Date performed?	Which facility?
_____	_____	_____
_____	_____	_____
_____	_____	_____

### HOSPITALIZATIONS

Have you ever been hospitalized other than for surgery? \_\_\_\_\_ No \_\_\_\_\_ Yes  
If yes describe.

Reason for hospitalization

When?

Which facility?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### FAMILY HISTORY

Have either your Mother/Father/Brothers/Sisters had a Heart Attack, Stent or Stroke?  
\_\_\_\_\_ No \_\_\_\_\_ Yes

### SOCIAL HISTORY

Have you ever smoked or used smokeless tobacco? \_\_\_\_\_ No \_\_\_\_\_ Yes Quit \_\_\_\_\_ / \_\_\_\_\_  
**Mo Yr**

How many packs per day? \_\_\_\_\_ How long have you smoked? \_\_\_\_\_