PAST MEDICAL HISTORY (check all that apply) ☐ No Past Medical History

☐ Diabetes ☐ Stroke ☐ Heart Disease ☐ Heart Attack ☐ CHF/heart failure

☐ High Blood Pressure ☐ Gout ☐ COPD/lung ☐ Arthritis ____________

☐ High Cholesterol ☐ Thyroid ☐ Liver Disease ☐ Kidney Disease

☐ Spinal Stenosis ☐ Lower Back Pain ☐ Fibromyalgia ☐ Cancer ________

☐ Gerd/acid reflux ☐ Swelling of leg/feet ☐ DVT/blood clot ☐ Smoking

☐ Other ____

PREVIOUS SURGERIES: (List procedure and year performed) ☐ No Surgical History

_______________ _________________________ ___________________

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_______________ _________________________ ___________________

PRESCRIPTION MEDS: (List name and dosage) ☐ No Prescription Medications

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DRUG ALLERGIES: (Check all that apply) ☐ No known allergies

☐ Penicillin ☐ Codeine ☐ Latex ☐ Antibiotics ☐ Local Anesthetics

☐ Aspirin ☐ Sulfa ☐ Adhesive Tape ☐ Other _______________________

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