

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_

\* PLEASE CIRCLE IF YOU CURRENTLY HAVE, AND INDICATE DATES APPLICABLE:

A-FIB \_\_\_\_\_

ACUTE OR CHRONIC RENAL FAILURE \_\_\_\_\_

ASTHMA \_\_\_\_\_

BLOOD CLOT / DVT \_\_\_\_\_

CANCER TYPE: \_\_\_\_\_

CONGESTIVE HEART FAILURE \_\_\_\_\_

COPD \_\_\_\_\_

DIABETES \_\_\_\_\_

GLAUCOMA \_\_\_\_\_

HEART ATTACK \_\_\_\_\_

HEART SURGERY TYPE: \_\_\_\_\_

HEPATITIS A B C \_\_\_\_\_

HIGH BLOOD PRESSURE \_\_\_\_\_

MITRAL VALVE PROLAPSE \_\_\_\_\_

NEUROPATHY \_\_\_\_\_

OSTEOPOROSIS \_\_\_\_\_

PACEMAKER / DEFIBRILLATOR / STENT \_\_\_\_\_

PULMONARY EMBOLUS \_\_\_\_\_

SLEEP APNEA \_\_\_\_\_

STROKE \_\_\_\_\_

OTHER \_\_\_\_\_

THYROID DISEASE \_\_\_\_\_

PREGNANT OR BREASTFEEDING YES / NO

PLEASE LIST ANY CURRENT INFECTIONS \_\_\_\_\_