

About You:

Age: _____ Height: _____ Weight: _____ Right/Left Handed? _____

Occupation: _____ Highest Grade Completed _____

Hobbies? _____

Do you regularly exercise? _____ Type of exercise: _____
Yes/No

Minutes/session _____ times/week _____

Do you use tobacco? _____ If yes, how many per day: _____ Cigarettes _____ Cigars _____ Chewing Tobacco
Yes/No

Number of Alcoholic beverages per day: _____ Per week: _____

Do you use a cane, walker, crutches, wheelchair? (list any used)

Have you or a family member ever been diagnosed or treated for any of the following conditions?

YOU

FAMILY MEMBER

List year of Diagnosis

- High Blood Pressure/Hypertension
- High Cholesterol/Fats
- Heart Problems(attacks, failure, angina, atrial fibrillation, etc)
- Stroke, Ministroke, TIAs
- Cancer or Tumors
- Nervous Breakdown, Anxiety, Depression, Nerves
- Kidney or Liver Problems
- Lung or Breathing Problems, Asthma, Emphysema, Bronchitis
- Thyroid Problems
- Seizures, Blackouts, Syncope (Fainting)
- Lupus or Rheumatoid Arthritis
- Blood Clots, Thrombosis, Phlebitis, Embolism
- Migraine or Headache
- Head Injury or Concussion
- Neck or Back Injury, Whiplash
- Glaucoma, Cataracts, eye problems
- Ulcers, Gastritis, Reflux, Colitis
- Diabetes, High Blood Sugar

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- Kidney or Liver Problems
- Lung or Breathing Problems, Asthma, Emphysema, Bronchitis
- Thyroid Problems
- Seizures, Blackouts, Syncope (Fainting)
- Lupus or Rheumatoid Arthritis
- Blood Clots, Thrombosis, Phlebitis, Embolism
- Migraine or Headache
- Multiple Sclerosis
- Alzheimers Disease, Dementia
- Glaucoma, Cataracts, eye problems
- Ulcers, Gastritis, Reflux, Colitis
- Diabetes, High Blood Sugar

Other Conditions: _____

Other Conditions: _____

Do you have any trouble with:

- | | | |
|--|--|---|
| <input type="checkbox"/> Weight Loss or Gain | <input type="checkbox"/> Numbness | <input type="checkbox"/> Vertigo, Spinning |
| <input type="checkbox"/> Fever, Chills | <input type="checkbox"/> Weakness | <input type="checkbox"/> Memory, Concentration |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Arthritis, Joint Pain | <input type="checkbox"/> Vision | <input type="checkbox"/> Bowel or Bladder Control |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Speaking | <input type="checkbox"/> Swallowing |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Cramps | <input type="checkbox"/> Staggering, Falling |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Head Pain, Headache | |

Do you have a Living Will? _____ Durable Power of Attorney? _____

If yes, please bring a copy to your appointment.