About You:

Age: ___________ Height: ___________ Weight: ___________ Right/Left Handed: ___________ Highest Grade Completed: ___________

Occupation: ___________ Hobbies: ___________

Do you regularly exercise? Yes/No ________ Type of exercise: ___________ Minutes/session: ___________ times/week: ___________

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

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**

- 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

**FAMILY MEMBER**

- 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
- Multiple Sclerosis
- Alzheimers Disease, Dementia
- Glaucoma, Cataracts, eye problems
- Ulcers, Gastritis, Reflux, Colitis
- Diabetes, High Blood Sugar

**Other Conditions:**

Do you have any trouble with:

- Weight Loss or Gain
- Fever, Chills
- Rash
- Arthritis, Joint Pain
- Dizziness
- Chest Pain
- Hearing
- Numbness
- Weakness
- Ringing in Ears
- Vision
- Speaking
- Cramps
- Head Pain, Headache

Vertigo, Spinning
- Memory, Concentration
- Sleep
- Bowel or Bladder Control
- Swallowing
- Staggering, Falling

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

If yes, please bring a copy to your appointment.