NAME:_____ **DATE:**_____

5) PLEASE LIST ALL PRIOR SURGERY:

Surgery Date of Surgery

_____

_____

_____

_____

_____

_____

6) YOUR PERSONAL MEDICAL HISTORY: PLEASE CHECK IF YOU HAVE THE FOLLOWING:

____DIABETES
____HYPERTENSION
____HEART TROUBLE (Type:_____)
____BLOOD THINNERS (Name:_____Why?_____)
____BLEEDING TENDENCY DISORDER
____CANCER (Type:_____)
____REFLUX
____COPD
____STROKE/TIA
____THYROID DISEASE/PROBLEMS
____SEIZURES
____ARTHRITIS/GOUT
____AIDS/HIV
____OTHER DISEASE or ILLNESS NOT LISTED (List:_____)

**Do you use C-PAP machine? NO or YES

7) Have you had a colonoscopy? NO____ YES____ (Most recent date_____)

8) Have you had a pneumonia shot? NO____ YES____ (Most recent date_____)