Medical History

Do you have or have you ever had any of the following?

Congestive Heart Failure	YES	NO	Valvular Disease	YES	NO
High Blood Pressure	YES	NO	Stents	YES	NO
Heart Attack	YES	NO	Arrhythmia	YES	NO
Atherosclerotic Disease (CAD)	YES	NO	Coronary Artery Bypass Graft	YES	NO
Angioplasty	YES	NO	Angina	YES	NO
Chronic Obstructive Pulmonary Disease	YES	NO	Asthma	YES	NO
Emphysema	YES	NO	Recent Pneumonia	YES	NO
Peripheral Artery Disease	YES	NO	Stroke/TIA	YES	NO
Acquired Respiratory Distress Syndrome	YES	NO	Chronic Bronchitis	YES	NO
Diabetes	YES	NO	Thyroid Disorders	YES	NO
Arthritis	YES	NO	Osteoporosis	YES	NO
Allergies	YES	NO	Anxiety or Panic Disorders	YES	NO
Neurological Disease (MS, Parkinson's)	YES	NO	Depression	YES	NO
Headaches	YES	NO	Gastrointestinal Disease	YES	NO
Kidney, Bladder, Prostate Problems	YES	NO	Visual Impairment	YES	NO
Incontinence	YES	NO	Hearing Impairment	YES	NO
Back or Neck Pain	YES	NO	Sleep Dysfunction	YES	NO
Hepatitis/AIDS	YES	NO	Prosthesis/Implants	YES	NO
Cancer	YES	NO	High Cholesterol	YES	NO

Prior Surgeries:

_____

_____

_____

Medication:

NAME	DOSE	FEQUENCY