



**Please answer the following questions**

Have you ever had heart trouble? Yes No  
Murmurs / Irregular heart beat? Yes No  
Congestive heart failure? Yes No  
Leg swelling Yes No  
Shortness of breath after climbing  
1 flight of stairs? Yes No  
Heart Attack? Yes No  
Angina? Yes No  
Stress Test? Yes No

Have you ever been treated for High  
Blood pressure? Yes No

Have you ever had a stroke? Yes No  
Seizures Yes No  
Frequent headaches? Yes No  
Neck or back problems? Yes No

Do you have any lung diseases? Yes No  
Asthma Yes No  
Emphysema Yes No  
Pulmonary embolism Yes No  
Tuberculosis Yes No  
Chronic cough Yes No  
Sleep apnea Yes No  
Abnormal chest x-ray Yes No  
Do you smoke? Yes No  
Smoked in the past? Yes No  
How many packs per day? \_\_\_\_\_  
When did you quit? \_\_\_\_\_

Have you ever had liver disease? Yes No  
Hepatitis Yes No  
Jaundice Yes No  
Cirrhosis Yes No  
Do you drink alcohol regularly? Yes No  
How much? Per day \_\_\_\_\_  
Per week \_\_\_\_\_  
Have you ever used intravenous drugs? Yes No

Do you have bleeding problems? Yes No  
Clotting problems? Yes No  
Sickle cell anemia? Yes No  
Received a blood transfusion? Yes No

Have you had recent weight gain or loss? Yes No  
Do you have thyroid disease? Yes No  
Do you have diabetes? Yes No  
Take Insulin? Yes No  
Have you ever had kidney disease? Yes No  
Prostate Disease Yes No  
Been on Dialysis Yes No

Have you ever had stomach ulcers? Yes No  
Hiatal Hernia Yes No  
Esophageal reflux Yes No

Have you had recent exposure to measles,  
Mumps or chicken pox? Yes No  
Have you ever been hospitalized for  
infection? Yes No  
Are you HIV positive? Yes No

Could you be pregnant? Yes No

Do you wear glasses? Yes No  
Contact lenses? Yes No

Do you wear dentures? Yes No  
Have loose teeth? Yes No

Do you use:  
Wheelchair? Yes No  
Cane or walker? Yes No  
Hearing aids? Left Right No  
Oxygen? Yes No  
CPAP Yes No  
Any other medical device? Yes No