Emergency Information

Name of nearest relative not living with you ______________________________

Complete Address ______________________________

Phone ____________________ Relationship ____________________

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? □Yes □No

If yes, for what? ______________________________

Hospital or Physician's name ____________________ Phone ____________________

____________________ Hospital or Physician's City __________

____________________ State ____________________

Have you taken any medications or drugs in the past two years? □Yes □No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the counter medicines)

□Yes □No

If yes, please explain ______________________________

Have you been to the doctor to check for heart problems? □Yes □No

If so, what are the problems? ______________________________

____________________ Do you use tobacco? □Yes □No

Do you use alcohol or other controlled substances? □Yes □No

Women only:

Are you pregnant or think you may be pregnant? □ Yes □No Are you nursing? □Yes □No

Are you taking birth control pills? □Yes □No

Have you ever had a sleep study or diagnosed with sleep apnea? □Yes □No

Indicate which of the following you have had or have at present:

AIDS/HIV	□Yes	□No	Difficulty Breathing	□Yes	□No	Lupus	□Yes	□No
Alcohol/Drug Abuse	□Yes	□No	Emphysema	□Yes	□No	Mitral Valve Prolapse	□Yes	□No
Allergies/Hives	□Yes	□No	Epilepsy or Seizures	□Yes	□No	Nervousness/Anxiety	□Yes	□No
Anemia	□Yes	□No	Fainting or dizzy spells	□Yes	□No	Neurological Disorders	□Yes	□No
Arthritis/Rheumatism	□Yes	□No	Frequent Headaches	□Yes	□No	Psychiatric Care	□Yes	□No
Artificial Heart Valve	□Yes	□No	Glaucoma	□Yes	□No	Radiation Therapy	□Yes	□No
Artificial Bones/Joints	□Yes	□No	Hay Fever	□Yes	□No	Rheumatic/Scarlet Fever	□Yes	□No
Asthma	□Yes	□No	Heart (surgery, disease,			Shingles/Chicken Pox	□Yes	□No
Blood Disease	□Yes	□No	attack)	□Yes	□No	Sickle Cell Disease	□Yes	□No
Blood Transfusion	□Yes	□No	Heart Pacemaker	□Yes	□No	Sinus Trouble	□Yes	□No
Bruise Easily	□Yes	□No	Heart Murmur	□Yes	□No	Snoring/Sleep Apnea	□Yes	□No
Cancer/Chemotherapy	□Yes	□No	Hemophilia/Abnormal			Stomach Problems/Ulcers	□Yes	□No
Chest Pain	□Yes	□No	Bleeding	□Yes	□No	Stroke	□Yes	□No
Cold Sores/Herpes	□Yes	□No	Hepatitis A B C (circle)	□Yes	□No	Swollen Ankles	□Yes	□No
Colitis	□Yes	□No	High or low pressure	□Yes	□No	Thyroid Problems	□Yes	□No
Contact Lenses	□Yes	□No	HPV	□Yes	□No	Tuberculosis	□Yes	□No
Cortisone Medicine	□Yes	□No	Jaundice	□Yes	□No	Tumors	□Yes	□No
Diabetes	□Yes	□No	Kidney Trouble	□Yes	□No	Venereal Disease (STI)	□Yes	□No
If yes, last a1c reading __________			Liver Disease	□Yes	□No			

Please list any serious medical condition(s) that you have ever had not listed above:

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Are you aware of having an allergic (or adverse) reaction to any of the following:

Aspirin	□Yes	□No	Latex	□Yes	□No
Codeine	□Yes	□No	Penicillin or other antibiotics	□Yes	□No
Anesthetics	□Yes	□No	Sedatives	□Yes	□No
Erythromycin	□Yes	□No	Sulfa Drugs	□Yes	□No
Iodine	□Yes	□No	Tetracycline	□Yes	□No
Jewely/Metals	□Yes	□No	Other ____________________		

Patient Signature:____