Print Patient Name: _____ DOB_____

Referring Provider: _____
Occupation: _____

PCP_____

CARDIOLOGIST_____

(Medical Staff Only)
Patient Label

HEALTH SCREENING: Please answer the following questions and **explain all yes answers**.

Are you currently taking blood thinners?	No	Yes	
Have you had an infection after surgery?	No	Yes	
Have you ever had a blood clot?	No	Yes	
Any problems with anesthesia?	No	Yes	Describe: _____
Complication following surgery?	No	Yes	Describe: _____
Do you have an allergy to Latex?	No	Yes	
Do you have a metal allergy?	No	Yes	Describe: _____
What was your last HA1C?	N/A		Value: _____
Do you use a walker or cane?	No	Yes	
Do you use a CPAP or Bipap machine?	No	Yes	Pressure setting: _____
Do you live at home alone?	No	Yes	
Are you pregnant?	No	Yes	

Have you had a heart attack (MI), Stroke, or Stent within the last 2 years? No Yes

Have you been hospitalized in the past 6 months? No Yes

MEDICAL HISTORY: Please ensure **ALL** medical conditions are checked or listed

☐	Hypertension/High blood pressure	☐	Diabetes
☐	Heart disease/coronary artery disease	☐	Rheumatoid arthritis
☐	Irregular Heartbeat/arrhythmia	☐	Gout
☐	High cholesterol	☐	Osteoporosis
☐	Peripheral vascular disease	☐	Thyroid disease
☐	Stroke	☐	Reflux disease/Heartburn
☐	Sleep apnea	☐	Stomach ulcers
☐	Asthma	☐	Cancer
☐	COPD/Emphysema	☐	kidney disease
☐	Blood clots/abnormal clotting	☐	HIV/AIDS
☐	Abnormal bleeding	☐	Hepatitis

FAMILY HISTORY: If **yes** please explain

Do you have a family history of blood clots or easily bleeding? No Yes _____

Do you have a family history of problems with anesthesia? No Yes _____

Any other family history you would like to share? No Yes _____

(Medical Staff Only) Vitals: Height_____ Weight_____ Blood Pressure_____ Pulse_____ BMI_____

MEDICATIONS:

Please list or attach ***ALL*** prescription ***AND*** over the counter medications

Name / Dose	**How often**	**Name / Dose**	**How often**

Are you on Injectable Medications? No Yes
Are you on Weight Loss Medications? No Yes
Do you take Phentermine or Jardiance? No Yes

MEDICATION ALLERGIES: **Please list all allergies and state reaction**

Medication: **Reaction** (what happened)	**Medication**: **Reaction** (what happened)

SURGICAL HISTORY: Please include all surgeries you have had in the past

PROCEDURE: **Year:**	**PROCEDURE:** **Year:**

REVIEW OF SYSTEMS: Do you **CURRENTLY** have any of the following conditions

General (Fever, chills, weight loss/gain)	No	Yes	Digestion (Reflux, ulcers, pain)	No	Yes
Eyes	No	Yes	Bowels (Constipation, diarrhea)	No	Yes
Ears/Nose/Throat	No	Yes	Appetite, Weight gain/loss, weakness	No	Yes
Heart (Chest pain, palpitations, murmur)	No	Yes	Skin (Rashes, sores, itching)	No	Yes
Lungs, breathing Shortness of breath	No	Yes	Balance, dizziness, numbness, tingling	No	Yes

Please explain all yes answers here:

SOCIAL HISTORY:

Marital Status: Married □ Single □ Widow(er) □ Divorced □
Do you drink alcohol? Yes □ No □ How much? (circle) rarely occasionally daily weekly
Do you currently smoke, vape or use chewing Tobacco, or pouches? Yes □ No □
How much? _____ packs per day for _____ years Quit □ (Year you quit: ____)
History of substance abuse? Yes □ No □ If yes, what substance:
Do you use Marijuana? Yes □ No □ If yes, how often? _____

Patient Signature _____ Date _____

Reviewing M.D/PA_____ Date_____