

DISCLAIMER: The information contained in this form is for the sole use of Spectra Health as is appropriate under the HIPAA Privacy Rule. These questions are asked to better serve you as a patient of Spectra Health.

Patient's Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Phone:** _____ **Height:** _____ **Weight:** _____

Address: _____
Street City State Zip

Insurance: _____ **Email:** _____

Medical History

Have you ever been hospitalized? ☐ Yes ☐ No **If Yes, what for?** _____

Please mark all conditions you are currently being treated for or have been treated for in the past:

- | | | |
|---|--|--|
| ☐ ADHD | ☐ Diverticular Disease | ☐ Osteoporosis |
| ☐ Anemia | ☐ Esophageal Reflux | ☐ Pacemaker |
| ☐ Angina (chest pain) | ☐ Fibromyalgia | ☐ Peripheral Vascular Disease |
| ☐ Anticoagulant Therapy | ☐ Gastric Ulcer | ☐ Pregnancy |
| ☐ Anxiety | ☐ Heart Disease | Due Date _____ |
| ☐ Arthritis | ☐ Hearing Loss | ☐ Radiation Treatment |
| ☐ Artificial Heart Valves | ☐ Hepatitis | ☐ Renal Disease |
| ☐ Asthma | Type _____ | ☐ Seizure Disorder |
| ☐ Atrial Fibrillation | ☐ High Blood Pressure | ☐ Sensory Disorder |
| ☐ Autism | ☐ High Cholesterol | Explain _____ |
| ☐ Bisphosphonate Use | ☐ HIV/AIDS | _____ |
| Type _____ | ☐ Implantable Defibrillator | _____ |
| ☐ Cancer | ☐ Infective Endocarditis | _____ |
| Type _____ | ☐ Joint Replacement | ☐ Stroke Syndrome |
| ☐ Chemotherapy | Type _____ | ☐ Traumatic Brain Injury |
| ☐ Chronic Pain | ☐ Lung Disease | ☐ Thyroid Disease |
| ☐ Cirrhosis | ☐ Liver Disease | ☐ Tuberculosis |
| ☐ Congenital Heart Defect | ☐ Menopause | ☐ Valvular Heart Disease |
| ☐ Congestive Heart Failure | ☐ Migraine Headaches | |
| ☐ COPD | ☐ Mitral Valve Prolapse | |
| ☐ Crohn's/Colitis | ☐ Need for Premedication | |
| ☐ Depression | ☐ Organ Transplant | |
| ☐ Diabetes Last A1C _____ | Type _____ | |

Please list any past or current treatment or surgeries not listed above:

Do you have any environmental, food, or medication allergies? ☐ Yes ☐ No

If Yes, please list and describe reaction: _____

Current Medications	Reason for Medication

Signed _____ **Date** _____