

PERSONAL AND FAMILY MEDICAL HISTORY

CANCER/ONCOLOGY

<input type="checkbox"/>	Cancer - Type _____
<input type="checkbox"/>	Cancer - Type _____
<input type="checkbox"/>	Cancer - Type _____
<input type="checkbox"/>	Skin Cancer - Basal Cell
<input type="checkbox"/>	Skin Cancer - Squamous Cell
<input type="checkbox"/>	Skin Cancer - Melanoma

CARDIOLOGY/HEMOTOLOGIC

<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Aortic Value Disorder
<input type="checkbox"/>	Bleeding / Clotting Disorder
<input type="checkbox"/>	Congestive Heart Failure
<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	Heart Disease - Arrhythmia/A-Fib
<input type="checkbox"/>	Heart Disease - Pacemaker
<input type="checkbox"/>	Heart Disease - Stent
<input type="checkbox"/>	Heart Disease - implanted cardio defibrillator
<input type="checkbox"/>	Heart Murmur /Mitral Valve Prolapse
<input type="checkbox"/>	Coronary Artery Disease
<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Peripheral Vascular Disease
<input type="checkbox"/>	Stroke/TIA
<input type="checkbox"/>	Heart Value Disorders
<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	Tuberculosis

ENDOCRINOLOGY

<input type="checkbox"/>	Diabetes - Type _____
<input type="checkbox"/>	Hyperthyroidism
<input type="checkbox"/>	Hypothyroidism

ENT

<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Vertigo
<input type="checkbox"/>	Hearing Problems
<input type="checkbox"/>	Nosebleeds

GYNECOLOGY

<input type="checkbox"/>	Chlamydia
<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	Fibroids
<input type="checkbox"/>	Hysterectomy
<input type="checkbox"/>	Osteopenia

OTHER

<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	Drug User
<input type="checkbox"/>	Smoker

OTHER

<input type="checkbox"/>	Chicken Pox
<input type="checkbox"/>	Measles
<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Shingles

GASTROINTESTINAL

<input type="checkbox"/>	Appendicitis
<input type="checkbox"/>	Diverticulosis
<input type="checkbox"/>	Gall Stones
<input type="checkbox"/>	Gastrointestinal Bleeding
<input type="checkbox"/>	GERD (ACID Reflux)
<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Hepatitis A, B, or C
<input type="checkbox"/>	Irritable Bowel Syndrome/Crohns Disease
<input type="checkbox"/>	Stomach Ulcers

NEUROLOGICAL

<input type="checkbox"/>	Alzheimer's
<input type="checkbox"/>	Balance Disorders
<input type="checkbox"/>	Dementia
<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Head Injury
<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Lupus
<input type="checkbox"/>	Lyme Disease
<input type="checkbox"/>	Meningitis
<input type="checkbox"/>	Migraines
<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	Neuropathy
<input type="checkbox"/>	Parkinson's
<input type="checkbox"/>	Seizures

MUSCULOSKELETAL/RHEUMATOLOGIC

<input type="checkbox"/>	Bursitis
<input type="checkbox"/>	Carpal Tunnel Syndrome
<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	Osteoarthritis
<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Chronic Joint Pains

PSYCHOLOGICAL

<input type="checkbox"/>	Depression
<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Schizophrenia
<input type="checkbox"/>	Bipolar Disorder
<input type="checkbox"/>	ADD/ADHD
<input type="checkbox"/>	PTSD

RESPIRATORY

<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Bronchitis/Pneumonia
<input type="checkbox"/>	Emphysema/COPD
<input type="checkbox"/>	Other Lung Disease

UROLOGICAL

<input type="checkbox"/>	Chronic Kidney Disease
<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	Urinary Incontinence
<input type="checkbox"/>	Dialysis (Hemo/Peritoneal)
<input type="checkbox"/>	Kidney Failure
<input type="checkbox"/>	Urinary Tract/Kidney infection

ANESTHESIA COMPLICATIONS

ALLERGIES