**O’CARROLL & ASSOCIATES, L.L.C.**

PATIENT NAME:  
CHIEF COMPLAINT: (please describe location and duration)

PERSONAL HISTORY 26. Blood clotting in lungs or legs……………………………………...YES or NO  
HAVE YOU EVER HAD (PLEASE CIRCLE YES OR NO) 27. Infectious disease of any kind………………………………...……YES or NO  
1. Surgery requiring anesthesia……………………………………..YES or NO 28. Colitis, gastritis, GERD…………………………………..……………..YES or NO  
  
2. Any joint replacement……………………………………………….YES or NO 29. Bladder, kidney disease………………………………………………..YES or NO  
  
3. Any valve replacement………………………………………………YES or NO 30. Cancer………………………………………………………………………….YES or NO  
  
4.Any ill effects related to an anesthetic………………………..YES or NO 31. Hepatitis-type \_\_\_\_\_........................................................YES or NO  
  
5. Fainting spells…………………………………………………….……….YES or NO **HABITS**  **NEVER OCCASIONALLY DAILY**  
  
6. Seizures or convulsions……………………………………….………YES or NO 32. Street drugs \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
  
7. Stroke………………………………………………………………….……..YES or NO 33. Alcohol \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
  
8. Depression or mental illness………………………………….……YES or NO 33. Tobacco \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Cigarettes \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_  
9. Thyroid problems……………………………………………….…….…YES or NO Cigars \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_  
10. Chronic or frequent coughs……………………………….………YES or NO Pipe \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_  
11. Shortness of breath………………………………………….……….YES or NO Caffeine \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_  
12. Asthma or hay fever……………………………………….…………YES or NO   
  
13.Lung disease (pneumonia, TB, bronchitis)……….…………YES or NO **ALLERGIES**  
 34. Any drug allergies……………………………………………………YES or NO  
14. High blood pressure………………………………………………….YES or NO If “yes” specify   
  
15. Rheumatic fever or heart disease………………………………YES or NO 35. Any environmental/food allergies…………………………….YES or NO  
 If “yes” specify   
16. Rheumatoid arthritis………………………………………………….YES or NO  
  
17.Heart attack………………………………………………………………..YES or NO **PLEASE LIST CURRENT MEDICATIONS**  
  
18. Pacemaker or defibrillator………………………………………….YES or NO   
  
19. Chest pain………………………………………………………………….YES or NO  
  
20. Palpitation or fluttering heart…………………………………….YES or NO  
  
21. Bleeding tendencies……………………………………………………YES or NO  
  
22.Diabetes Type 1 or Type 2…………………………………………..YES or NO 35. Do you take aspirin…………………………………………………..YES or NO  
  
23. Jaundice or liver disease…………………………………………….YES or NO 36. Do you take any supplements…………………………………..YES or NO   
  
24. Blood clotting in lungs or legs…………………………………....YES or NO 37. Do you take Coumadin or Plavix………………………………..YES or NO  
  
25. Infectious disease of any kind………………………………...…YES or NO 38. Do you take “Blood Thinners” of any type…………………YES or NO  
 If “yes” please specify

FAMILY HISTORY

PLEASE ANSWER WITH A YES OR NO IF ANYONE IN YOUR FAMILY HAS ANY OF THE FOLLOWING:

1. Alcoholism…………………………………………………………..……YES or NO 16. Type 2 diabetes…………………..………………………………….YES or NO
2. Allergies/Hay fever……………………………………………………YES or NO 17. Epilepsy………………………………………………………………….YES or NO
3. Anemia……………………………………………………………………..YES or NO 18. Gastrointestinal Disease………………………………………….YES or NO
4. Anxiety………………………………………………………………………YES or NO 19. Heart Murmur…………………………………………………………YES or NO
5. Asthma………………………………………………………………………YES or NO 20. Hepatitis………………………………………………………………….YES or NO
6. Atrial fibrillation…………………………………………………………YES or NO 21. High blood pressure………………………………………………….YES or NO
7. Cardiovascular disease……………………………………………….YES or NO 22. Kidney infections………………………………………………………YES or NO
8. Cirrhosis/Liver disease………………………………………………..YES or NO 23.Kidney stone……………………………………………………………..YES or NO
9. Colitis/bowel……………………………………………………………..YES or NO 24. Migraine………………………………………………………….……….YES or NO
10. Cancer……………………………………………………………………….YES or NO 25. Osteoarthritis……………………………………………………………YES or NO
11. COPD/Lund disease……………………………………………………YES or NO 26. Osteoporosis…………………………………………………………….YES or NO
12. CRF (Kidney disease/failure)………………………………………YES or NO 27. Neurological disease/disorder……………………..…………..YES or NO
13. DVT (Clotting in legs)………………………………………………….YES or NO 28. Pulmonary disease……………………………………………………YES or NO
14. Depression…………………………………………………………………YES or NO 29. Rheumatoid arthritis……………………………………..…………YES or NO
15. Type 1 diabetes…………………………………………………………..YES or NO 30. Thyroid disease………………………………………………………..YES or NO

**Signature: Date:**