Patients Information Worksheet - Please complete and return at the end of the class

	Name:	Age: Email:					
		<u>NO</u>	<u>YES</u>				
HEALTH HISTORY:							
1.	Coronary Artery Disease						
	Heart Bypass Surgery			If yes, when?			
	Heart Stent Surgery	***************************************		If yes, When?			
2.	Congestive Heart Failure						
3.	High Blood Pressure	***************************************					
4.	Blood Clots (DVT)						
5.	Kidney Disease		<u></u>				
6.	Sleep Apnea						
	• Use CPAP						
7.	Diabetes	***************************************		If yes, Type I: Type II:			
8.	Depression		and the second s				
9.	Anxiety						
10.	Panic attack		1000				
<u>P</u> A	IN: Are you on any of the following	g medicines?	<u>?</u>				
		<u>NO</u>	<u>Yes</u>	If yes, since when?			
•	Anti-inflammatory		- 1 - 10 - 11 - 12 - 12 - 12 - 12 - 12 -				
•	Narcotic		Market				
•	Under care of pain doctor						
1.	BLOOD THINNERS	<u>NO</u>	<u>YES</u>	If yes, since when?			
•	Coumadin						
•	Plavix						

•	Aspirin			
	Others			
	Reason			
MI	SCELLANEOUS:	<u>No</u>	<u>Yes</u>	
1.	Confusion			
	 Daytime 			
	 Nighttime 			
	With a pain medication			
2.	Smoke: Cigarettes/day			
3.	Drinks:/Week			
4.	Is there anything else you would like me to	know?		
AL	LERGIES:			
	Latex: Yes	No		
	Medications Allergies:			
	Food Allergies:			
<u>SP</u>	ECIAL DIET CONSIDERATIONS:			
		se leave thi -10 as expla * 0 is not a United HURTS LITTLE MORE	S blank until class ined, what is your preal pain goal HURTS HURTS EVEN MORE WHOLE LOT	10 HURTS

What is *your* pain goal?