

I have numbness and/or tingling in my: () Right arm, () Left arm, () Both arms

My pain is: () Sharp () Dull () Burning () Achy () Throbbing

My pain is worse when I:

- | | | |
|---------------------------------|---------|--------|
| Cough or sneeze: | () Yes | () No |
| Sit: | () Yes | () No |
| Bend: | () Yes | () No |
| Lift: | () Yes | () No |
| Push: | () Yes | () No |
| Turn My Head: | () Yes | () No |
| My pain wakes me up at night: | () Yes | () No |
| Weather changes affect my pain: | () Yes | () No |

OTHER PAIN

() I do not have other pain

Area of complaint: _____

My pain began () Gradually () Suddenly

I have pain () Sometimes () All the time

My pain goes into my () _____

My pain is: () Sharp () Dull () Burning () Achy () Throbbing

My pain is worse when I:

- | | | |
|---------------------------------|---------|--------|
| Cough or sneeze: | () Yes | () No |
| Sit: | () Yes | () No |
| Bend: | () Yes | () No |
| Lift: | () Yes | () No |
| Push: | () Yes | () No |
| Turn My Head: | () Yes | () No |
| My pain wakes me up at night: | () Yes | () No |
| Weather changes affect my pain: | () Yes | () No |
| Other _____ | () Yes | |

OTHER PAINS:

Please describe any current complaints that you are experiencing that were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

Please answer each question as completely as possible:

Do you have any of the following?

- | | | | |
|----|---|---|---|
| 1. | Hypertension? | Y | N |
| | If yes, is it a current condition? | Y | N |
| | Are you taking medication for it? | Y | N |
| | Name of medicine: _____ | | |
| 2. | Discomfort, pressure, or tightness in chest? | Y | N |
| | location: () front () back () left side () right side | | |
| | Do you have discomfort with exertion? | Y | N |
| 3. | Irregular heart rhythm or heart palpitation? | Y | N |
| | Does this occur at rest? | Y | N |
| | Does this occur with exertion? | Y | N |
| 4. | Do you have any type of heart condition? | Y | N |
| 5. | Repeated shortness of breath or difficulty breathing? | Y | N |
| | Does this occur at rest? | Y | N |
| | Does it last for long periods of time after exertion? | Y | N |
| 6. | Any type of lung disorder? | Y | N |
| | Asthma? | Y | N |
| | Chronic Bronchitis? | Y | N |
| | Emphysema? | Y | N |
| | Do you use any medications or breathing aids? | Y | N |
| 7. | Do you currently smoke or use tobacco products? | Y | N |

Do you have or have you ever had any of the following?

- | | | | |
|----|--|---|---|
| 1. | Diabetes? | Y | N |
| | If yes, is it under control? | Y | N |
| 2. | Low blood sugar? | Y | N |
| | If yes, is it under control? | Y | N |
| 3. | Elevated cholesterol? | Y | N |
| | If yes, is it under control? | Y | N |
| 4. | Hernia? | Y | N |
| | If yes, is it under control? | Y | N |
| 5. | Are you pregnant? | Y | N |
| 6. | Do you think you may be pregnant? | Y | N |
| 7. | Please list any medical conditions and/or complications you have that are not mentioned above: | | |

8. Please list any and all medications that you are currently taking:

9. Please list any and all medication allergies that you have:

Who should we call in case of emergency? _____
