



## MY HEALTH CONDITIONS:

## FAMILY CONDITIONS:

	Yes	No		Yes	No
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Lung problems	<input type="checkbox"/>	<input type="checkbox"/>	Lung problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver problems	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
GI problems	<input type="checkbox"/>	<input type="checkbox"/>	GI problems	<input type="checkbox"/>	<input type="checkbox"/>
Dentures/partials	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____ _____ _____ _____		
Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>			
Other: _____ _____ _____ _____					

## ADVANCE DIRECTIVES

## PAST SURGERIES

Living Will: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Durable Power of Attorney for Healthcare: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Surgery: \_\_\_\_\_ Date: \_\_\_\_\_