

Please check all of the following that apply to you:  None Apply

**No Yes Condition**

- History of Recent Infection
- Recent Fever
- HIV/AIDS
- Diabetes
- Corticosteroid Use
- Birth Control Pills
- High Blood Pressure
- Stroke (date) \_\_\_\_\_
- Dizziness/Fainting
- Numbness in Groin/Buttocks
- Urinary Retention
- Aortic Aneurysm
- Cancer/Tumor
- Osteoporosis
- Recent Trauma

**No Yes Condition**

- Prostate Problems
- Frequent Urination
- Pregnancy, # of births \_\_\_\_\_
- Abnormal Weight  Gain  Loss
- Epilepsy/Seizures
- Visual Disturbances
- History of Low/Mid Back Pain
- History of Neck Pain
- Arthritis
- History of Alcohol Use
- History of Tobacco Use
- History of Recent Infection
- Surgeries/Medications \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Family History:**

- Cancer  Diabetes  High Blood Pressure  Cardiovascular Problems/Stroke