Patient Name: Date of Birth:

Date: Provider name: Select Your Provider MRN:

HEALTH SCREENING: ***(females over age 65)***

Have you had a recent DXA (bone density scan) ☐ Yes ☐ No If Yes; when where:

ADVANCED DIRECTIVE:

Do you have an Advanced Directive ☐ Yes ☐ No / If yes, please name:

Do you have a Medical power of attorney ☐ Yes ☐ No / If yes, please name:

FAMILY HISTORY – Please check all that apply or check "No Family History" or "Family History Unknown"

Blood Clots: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Malignant Hyperthermia: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

☐ No Family History ☐ Family History Unknown

REVIEW OF SYSTEMS:

Is it ok to import your medications electronically? Select 1 ☐ None

☐ Allergy to iodine

☐ Allergy to latex

☐ Blood thinners (including aspirin)

☐ Chronic infection

☐ Currently pregnant or planning a pregnancy

☐ Defibrillator

☐ History of Blood Clots

☐ Tobacco Usage

☐ Metal Allergy

☐ On immunosuppressants

☐ Pacemaker

☐ Taking vitamins or supplements

☐ Taking narcotic pain medication, prescribed by:

☐ Resides at Nursing facility, where:

*****STAFF OFFICE USE ONLY***** Notes:

Height: **Weight:**

Blood Pressure: **O2:** **Pulse:**

Select 1

Tobacco Use:

Select 1

Once complete, please select "Submit" and return the kiosk to Reception