Oklahoma Joint Reconstruction Institute

Paul B. Jacob, DO

Dear Patient,
I would like to be the first to welcome you to ***Oklahoma Joint Reconstruction Institute***. We know you have many choices when it comes to your orthopedic needs and we thank you for trusting us with your care. We also want to thank you for taking your valuable time to fill out this packet of information as it will help us to better understand your condition.

Your first appointment will take approximately 30-45 minutes, and I will do my best to run as close as possible to your allotted appointment time. I do take care of urgent / emergent patients and I ask for your understanding and patience as from time to time your appointment may get rescheduled or I may be running late. I agree to extend the same courtesy to my patients' as I understand that unforeseen events may delay your arrival. I will do my best to accommodate late patients as my schedule permits. The attached packet will give you some important details on my practice. Please don't hesitate to contact me personally at ***drjacob@drpauljacob.com*** or my scheduler at **(405) 424-5426** with questions at any time during your care.

I am a Board Certified and Fellowship Trained Orthopedic Surgeon specializing in advance hip and knee replacement and adult reconstruction. I was fortunate to have to opportunity to complete my training at the world-renowned Cleveland Clinic in Cleveland, Ohio. My experience working with some of the world's leading experts in the field of adult reconstruction has allowed me to bring the most advanced techniques in minimally invasive surgery to the state of Oklahoma. This includes robotically assisted and minimally invasive hip and knee replacement utilizing the latest in rapid recovery protocols. My practice is solely focused on adult reconstruction of the lower extremity. I am committed to providing the most advanced techniques available for the residents of the state of Oklahoma and surrounding states.
I am passionate about achieving excellent results for my patients. A caring, professional approach to patient care combined with advanced surgical techniques is paramount. I also believe that monitoring of surgical results is critical. I am proud to say that our practice actively participates in the American Joint Replacement Registry.

WHAT TO BRING TO YOUR APPOINTMENT

- Driver's License or a valid ID
- Insurance information (card)
- Medical records from previous orthopedic surgeons
- Disc of previous imaging (X-rays, MRIs, CT scans etc.)
- List of medications (if any)
- Hospital medical records from previous surgeries

We realize that you will receive a great deal of information regarding your diagnosis and its associated treatment in a very short period of time. The amount and pace of information can be overwhelming. My website ***www.drpauljacob.com*** contains further information about my practice, research and experience. It also contains useful educational material on your diagnosis, surgical procedure and rehabilitation. If you are not provided with all the answers to your questions from these resources, please do not hesitate to contact us at any time for further assistance.
The prospect of undergoing a major surgery can sometimes be a stressful on you and your loved ones. We have designed a full program to inform you of your options, educate you on the process and minimize any stress / inconvenience that you may experience.
No matter your level of activity; whether you want to return to high level sport or be free of pain and enjoy everyday life, I am dedicated to helping you achieve your goals and live life to the fullest. I hope to be of assistance and look forward to meeting you soon.

Sincerely,

Paul B. Jacob D.O.
Oklahoma Joint Reconstruction Institute
Board Certified and Fellowship Trained Orthopedic Surgeon
Specializing in Advanced Reconstruction of the Hip and Knee
Email: drjacob@drpauljacob.com
Office: (405) 424-5426
Fax: (405) 424-5431
Website: www.drpauljacob.com

General Patient Information

Name:_____ Age:_____ Date Of Birth:_____ Height:_____ Weight:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Preferred contact method: ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Other:_____

Emergency Contact Name:_____ Phone #:_____

Pharmacy Name: _____ Phone#_____

Reason for the Visit?

- ☐ Hip Pain ☐ Left ☐ Right ☐ Bilateral
- ☐ Knee Pain ☐ Left ☐ Right ☐ Bilateral
- ☐ This is a second opinion
- ☐ I have a problem with my existing hip / knee replacement
- ☐ Other:_____
- ☐ When did symptoms begin?_____

Please let us know if you see any of the following physicians:

Primary care physician:_____ Cardiologist (heart doctor):_____

Rheumatologist (arthritis doctor):_____ Pulmonologist (lung doctor):_____

Pain Management:_____ Nephrologist (kidney doctor):_____

Other:_____

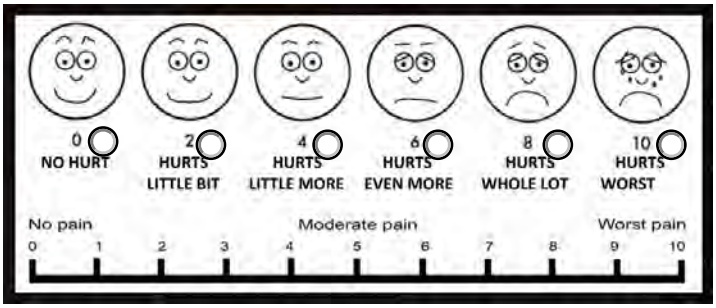
In your words please describe why you are seeing Dr. Jacob:_____

_____

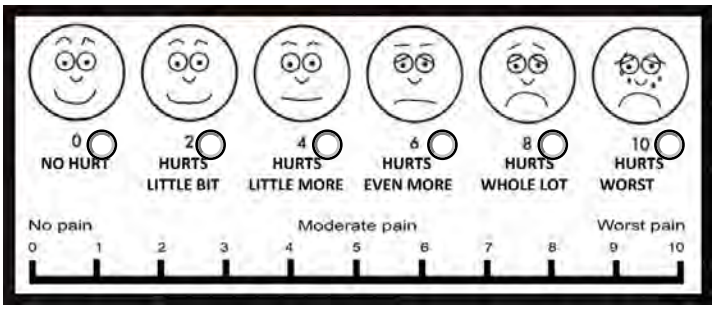
_____

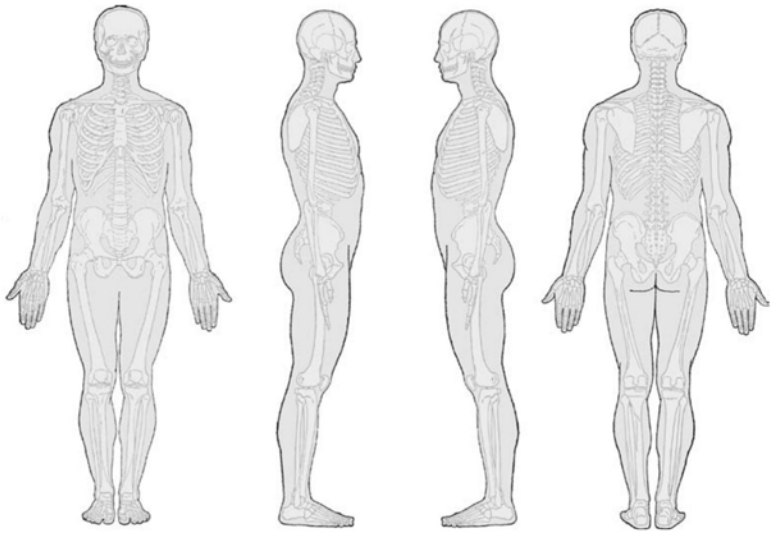
_____

Circle the number below that best corresponds to your pain at its ***BEST***



Circle the number below that best corresponds to your pain at its ***WORST***





Mark with an "X" where you are experiencing your pain

Please check all the boxes that describe your symptoms:

- ☐ Aching
- ☐ Throbbing
- ☐ Burning
- ☐ Numbness
- ☐ Tingling
- ☐ Heaviness
- ☐ Locking
- ☐ Grinding
- ☐ Stiffness
- ☐ Sharp
- ☐ Stabbing
- ☐ Electric shock
- ☐ Ants crawling
- ☐ Pins / Needles

Past Treatments

Insurances often will not approve major surgeries like hip or knee replacements until the patient has made attempts at conservative treatment for a minimum of 3 months. Please indicate all conservative treatments you have attempted below:

☐ I CAN NOT TAKE ANTI-INFLAMMATORY MEDICATIONS (REASON):_____

WEIGHT LOSS	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
ACTIVITY MODICATION	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
OVER THE COUNTER MEDS	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
PRESCRIPTION NSAID'S	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
PRESCRIPTION PAIN MEDS	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
TOPICAL MEDS	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
ALTERNATIVE MEDS	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
PHYSICAL THERAPY	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
AQUATIC THERAPY	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
CHIROPRACTIC	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
ACUPUNCTURE	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
HOME EXERCISE	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
STEROID INJECTION: #_____	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
GEL INJECTIONS: #_____	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
STEM CELL INJ. #_____	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
PRP INJECTIONS #_____	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
BRACING	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
WALKER / CANE / CRUTCH	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
REST / ICE / ELEVATION	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
NERVE BLOCKS	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
ARTHROSCOPIC SURGERY	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
OSTEOTOMIES	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
CARTILAGE TRANSPLANT	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
MICROFRACTURE	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
ORTHOTICS / TAPING	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks

Please describe any other treatments that you have attempted that are not listed above:_____

_____

_____

_____

_____

Review of Systems

Please check the box next to any of the symptoms you are experiencing currently.'

- ☐ I DO NOT HAVE ANY OF THE FOLLOWING SYMPTOMS
- ☐ I am currently pregnant

General:
- ☐ Chills
- ☐ Excessive Weight Gain
- ☐ Excessive Weight Loss
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Difficulty Sleeping

Cardiovascular:
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Palpitations
- ☐ Irregular Heartbeat
- ☐ Leg Swelling
- ☐ Pitting Edema
- ☐ Heart Murmur
- ☐ Fainting

Skin:
- ☐ Discoloration
- ☐ Easy Bruising
- ☐ Hives
- ☐ Rashes
- ☐ Open wounds
- ☐ Reaction to Metal
- ☐ Trouble Healing Wounds
- ☐ Have a wound care doctor

Gastrourinary:
- ☐ Urinary Frequency
- ☐ Urinary Retention
- ☐ Bowel Incontinence
- ☐ Bladder Incontinence
- ☐ Constipation

Hematology:
- ☐ Excessive Bruising
- ☐ Excessive Bleeding
- ☐ Blood Transfusions
- ☐ Anemia

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Loose stool
- ☐ Poor Appetite
- ☐ Poor Nutrition

Eyes / Ears / Nose / Throat:
- ☐ Vertigo / dizziness
- ☐ Hearing Loss
- ☐ Nose Bleeds
- ☐ Visual Changes
- ☐ Ringing in Ears

Endocrine:
- ☐ Excessive Thirst
- ☐ Heat Intolerance
- ☐ Cold Intolerance

Respiratory:
- ☐ Cough
- ☐ Wheezing
- ☐ Coughing Blood
- ☐ Require oxygen at home
- ☐ History of pneumonia
- ☐ Sleep apnea
- ☐ Use a CPAP

Shortness of breath when:
- ☐ Walking 2 blocks
- ☐ 1 flight of steps
- ☐ When I lay down

Psychiatric:
- ☐ Anxiety / Worrying
- ☐ Depression
- ☐ Excessive Crying
- ☐ Trouble Focusing
- ☐ Memory Loss
- ☐ Mood Swings
- ☐ Excessive Fear

Neurologic:
- ☐ Weakness
- ☐ Tremors
- ☐ Numbness
- ☐ Tingling
- ☐ Burning Sensation
- ☐ Seizures
- ☐ Memory Loss
- ☐ Headaches
- ☐ Paralysis
- ☐ Foot Drop
- ☐ Loss of Consciousness
- ☐ Headaches
- ☐ Slurred Speech

Musculoskeletal:
- ☐ Pain Going Up Stairs
- ☐ Pain Going Downstairs
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Muscle Atrophy
- ☐ Limping
- ☐ Joint Stiffness
- ☐ Leg Length Difference
- ☐ Use of Walker / Cane
- ☐ Trouble Getting Dressed
- ☐ Locking of Joints
- ☐ Popping of Joints
- ☐ Feeling of Instability
- ☐ Joint Swelling
- ☐ Muscle Cramps

Allergic / Immunologic:
- ☐ Hives
- ☐ Persistent Infections
- ☐ HIV Exposure
- ☐ Hepatitis Exposure
- ☐ Rash from Jewelry
- ☐ Rash from Meta

Past Medical History

- ☐ *I don't have any past medical history*

- ☐ Depression
- ☐ Anxiety
- ☐ Cancer
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Heart Burn / Reflux
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Gout
- ☐ Osteoporosis
- ☐ Thyroid Disease
- ☐ HIV

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hepatitis (other)
- ☐ Hiatal Hernia
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Psoriatic Arthritis
- ☐ Autoimmune Arthritis
- ☐ Fibromyalgia
- ☐ Alcohol Abuse/Addiction
- ☐ History of MRSA
- ☐ Anemia
- ☐ Deep Vein Thrombosis

- ☐ Pulmonary Embolism
- ☐ Bleeding Disorder
- ☐ Factor V Leiden
- ☐ Factor Deficiency
- ☐ Phlebitis
- ☐ History of Seizures
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Obstructive Sleep Apnea
- ☐ MRSA Infection
- ☐ Gastric Ulcers
- ☐ GI Bleeding
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Irritable bowel syndrome

Family History

☐ *I don't know my family history*

☐ Heart Attack	☐ High Blood Pressure	☐ Liver Disease
☐ Stroke	☐ Arthritis	☐ Arthritis
☐ TIA (Mini Stroke)	☐ Bleeding Problems	☐ Osteoporosis
☐ Cancer	☐ Blood Clots	☐ Rheumatoid Arthritis
☐ Breathing Problems	☐ Phlebitis	☐ Thyroid Disease
☐ Diabetes	☐ Pulmonary Embolism	☐ Autoimmune Disease

Please use the space below to provide any information you feel we should know about your past or current medical history:_____

_____

_____

_____

_____

_____

Past Surgical History

Please list all of the SURGERIES you have had

Surgery	*Hospital*	*Physician*	*Complications?*	*Year*
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

Please use the space below to provide any information you feel we should know about your past surgical history:_____

_____

_____

_____

Have you been hospitalized in the past 5 years? ☐ YES ☐ NO

If yes please describe:_____

_____

_____

_____

_____

_____

Social History

Tobacco Use:

- ☐ I Have Never Been a Smoker
- ☐ I Quit Smoking _____(*Days / Months / Years)* Ago
- ☐ I Smoked for _____ Years
- ☐ I Am a Current Cigarette Smoker
- ☐ I Have Smoked for _____ Years
- ☐ I Smoke _____ Packs Per Day
- ☐ I Use Smokeless Tobacco
- ☐ I Use Other Tobacco Products:_____
- ☐ I am interested in quitting

Alcohol Use:

- ☐ I Drink Alcohol Daily
- ☐ I Drink Socially
- ☐ I Don't Consume Alcohol

Drug Use:

- ☐ I Do Not Use Illegal Drugs
- ☐ I Use Recreational Drugs:_____

Exercise:

- ☐ I Do Not Exercise
- ☐ I Exercise Weekly
- ☐ Type of Exercise:_____

Occupation:

- ☐ I Am Currently Working as a(n):_____
- ☐ This was a workplace Injury
- ☐ Employer:_____
- ☐ I Am Currently Unemployed
- ☐ I am Retired from:_____

Lives with (check all that apply):

- ☐ Alone
- ☐ Spouse
- ☐ Children
- ☐ Parent(s)
- ☐ Grandparents
- ☐ Friend / Roommates

Do you have any stairs that you will need to navigate at home? ☐ YES ☐ NO If yes, how many stairs are there in the home:_____

Have you had one of the following heart tests:

(place a ✓)	**I have had the following**	**Year**	**Location of testing**
☐ Yes ☐ No	EKG		
☐ Yes ☐ No	Stress Test		
☐ Yes ☐ No	Echocardiogram (ultrasound of heart)		
☐ Yes ☐ No	Stent Placement?		
☐ Yes ☐ No	Cardiac surgery, please specify:		
☐ Yes ☐ No	Other cardiac procedure:		
☐ Yes ☐ No	Pacemaker/AICD		

if you marked yes to having a Pacemaker or AICD please provide the following info

Date pacemaker was last checked:_____ Model number or type of pacemaker:_____

This model is MRI safe: ☐ Yes ☐ No ☐ I am not sure

☐ I have my pacemaker card and can provide a copy

Please use the space below to provide any information you feel we should know about your cardiac history:_____

_____

_____

CURRENT MEDICATIONS

I am on the following ***PAIN MEDICATIONS***

☐ I am not currently taking any opioid based (narcotic) pain medications

1. Drug Name: _____ Dose: _____ How Often: _____
2. Drug Name: _____ Dose: _____ How Often: _____

Daily Medications (Please include over the counter medication and food supplements).

Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
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Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____

Are you on any Rheumatoid Arthritis or autoimmune disease medications? ☐ YES ☐ NO

- ☐ Methotrexate
- ☐ Sulfasalazine
- ☐ Hydroxychloroquine (Plaquenil)
- ☐ Leflunomide (Arava)
- ☐ Adalimumab (Humira)
- ☐ Etanercept (Enbrel)
- ☐ Golimumab (Symponi)
- ☐ Infliximab (Remicade)
- ☐ Abatacept (Orencia)
- ☐ Certolizumab (Cimzia)
- ☐ Rituximab (Rituxan)
- ☐ Tocilizumab (Actemra)
- ☐ Anakina (Kineret)
- ☐ Secukinumab (Cosentyx)
- ☐ Ustekinumab (Stelara)
- ☐ Belimumab (Benlysta)
- ☐ Tofacitinib (Xeljanz)
- ☐ Mycophenolate Mofetil
- ☐ Azathioprine
- ☐ Cyclosporine
- ☐ Tacrolimus

OTHER:_____

Allergies

(***please describe the reaction on the line provided***)

☐ NO KNOWN DRUG ALLERGIES
☐ I Have an allergy to ***LATEX***
☐ I Have an allergy to **TOPICAL IODINE (BETADINE)**
☐ I Have an allergy to **IV IODINE**

Drug Allergy	Reaction

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

ARE YOU CURRENTLY TAKING ANY *HORMONES?* (*ANYTHING* CONTAINING *ESTROGEN OR TESTOSTERONE*)	☐ YES	☐ NO
HAVE *YOU* EVER HAD A BLOOD CLOT ALSO CALLED A DEEP VEIN THROMBOSIS (DVT) IN YOUR LEGS?	☐ YES	☐ NO
HAVE *YOU* EVER HAD A BLOOD CLOT IN YOUR LUNGS OR A PULMONARY EMBOLISM (PE) IN YOUR LUNGS?	☐ YES	☐ NO
HAVE *YOU* EVER HAD PHLEBITIS (SUPERFICIAL BLOOD CLOT)?	☐ YES	☐ NO
HAS AN *IMMEDIATE FAMILY MEMBER* EVER HAD A DVT?	☐ YES	☐ NO
HAS AN *IMMEDIATE FAMILY MEMBER* EVER HAD A PE?	☐ YES	☐ NO
HAS AN *IMMEDIATE FAMILY MEMBER* EVER HAD A PHLEBITIS?	☐ YES	☐ NO
ARE *YOU* CURRENTLY ON A PRESCRIBED BLOOD THINNER THAT YOU ARE AWARE OF?	☐ YES	☐ NO
DO *YOU* HAVE ANY CARDIAC STENTS?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH KIDNEY FAILURE?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH BLEEDING ULCERS?	☐ YES	☐ NO
DO *YOU* HAVE TROUBLE TOLERATING OR HAVE YOU BEEN TOLD NOT TO TAKE ASPIRIN?	☐ YES	☐ NO
DO *YOU* HAVE A HISTORY OF SEIZURE DISORDERS?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH DEPRESSION?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH AN ANXIETY DISORDER?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH LIVER FAILURE?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH HIV / AIDS?	☐ YES	☐ NO
HAVE *YOU* EVER BEEN DIAGNOSED WITH HEPATITIS?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH DIABETES?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH HEART FAILURE?	☐ YES	☐ NO
HAVE *YOU* EVER HAD A TRANSIENT ISCHEMIC ATTACK (TIA)?	☐ YES	☐ NO
HAVE *YOU* EVER HAD A STROKE?	☐ YES	☐ NO
DO *YOU* HAVE A HISTORY OF ANESTHESIA COMPLICATIONS?	☐ YES	☐ NO
DO *YOU* WORK IN HEALTH CARE OR HAVE EXPOSURE TO MRSA?	☐ YES	☐ NO
DO *YOU* HAVE A HISTORY OF MRSA (STAPH) INFECTION?	☐ YES	☐ NO
DO *YOU* HAVE A HISTORY OF INFECTION AFTER SURGERY?	☐ YES	☐ NO
HAVE *YOU HAD TROUBLE HEALING AFTER PREVIOUS SURGERIES OR INJURIES*?	☐ YES	☐ NO
ARE *YOU* AN ORGAN TRANSPLANT RECIPIENT?	☐ YES	☐ NO
HAVE *YOU* HAD A PREVIOUS SURGERY ON THE OPERATIVE JOINT?	☐ YES	☐ NO
DO *YOU* BEEN ON STEROIDS FOR A LONG TIME (PREDNISONE, CORTISONE……..)?	☐ YES	☐ NO
HAVE *YOU* HAD A STEROID INJECTION ON THE OPERATIVE JOINT IN THE PAST 90 DAYS?	☐ YES	☐ NO
DO *YOU* USE TOBACCO PRODUCTS (ORAL TOBACCO, VAPING, CIGARS, CIGARETTES…)	☐ YES	☐ NO
IF YES, ARE *YOU* WILLING TO QUIT?	☐ YES	☐ NO
DO *YOU* HAVE AN ALLERGY TO TOPICAL IODINE?	☐ YES	☐ NO
DO *YOU* HAVE AN ALLERGY TO LATEX?	☐ YES	☐ NO
HAVE YOU HAD AN INFLUENZA VACCINE THIS YEAR? DATE:_____	☐ YES	☐ NO
HAVE YOU HAD A PNEUMONIA VACCINE THIS YEAR? DATE:_____	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH CANCER IN THE PAST 5 YEARS?	☐ YES	☐ NO

If yes, please provide the following information:

Type of cancer:_____ Date of Diagnosis:_____

Did you require any of these treatment(s)?

☐ Radiation Therapy Location:_____

☐ Chemotherapy Type:_____

☐ Lymph Node Removal Location:_____