PATIENT MEDICAL INFORMATION

Please Print Clearly on line above items

Are you currently taking any of these medications: Yes / No	ast Name	Fi	rst Name		Midd	le	Age
Yes/No Are you currently under a physician's care? If yes, explain: Yes/No Antibiotics Yes/No Digitalis Yes/No Blood Thinners Yes/No Nitroglycerin Yes/No Cortisone Yes/No High blood pressure medication Yes/No Other Yes/No Other Yes/No Digate is dosages: Yes/No High blood pressure medication Yes/No Sickle cell anemia, trait Yes/No Hepatitis, Liver disease Yes/No Contuisions Yes/No Contuisions Yes/No Sickle cell anemia, trait Yes/No Hepatitis, Liver disease Yes/No Contuisions Yes/No Contuisions Yes/No Asthma/Lung disease Yes/No Radiation Therapy Yes/No Radiation Therapy Yes/No Radiation Therapy Yes/No No Radiation Therapy Yes/No Heart disease Yes/No Swollen Ankles Yes/No Swollen Ankles Yes/No Heart murmur, "Leaky valve" Yes/No Low blood pressure Yes/No Angina Yes/No Valve damage, valve replacement	Address	Ci	ty -	State	ZIP	Home	Telephone
Are you currently taking any of these medications: Yes / No	MEDICAL I	NFORMATION			900 900 900		
Are you currently taking any of these medications: Yes / No	Yes/No Are	you currently under a physician'	s care?	11		25	2
Are you currently taking any of these medications: Yes / No	f yes, explain:	A 40		If yes, when	and why?		
Are you currently taking any of these medications: Yes / No							
HIV Status (circle) Positive Negative Unknown	Are you current	ly taking any of these medication	s:	l			
Please circle yes or no to each item: Yes / No				HTV Status	(circle) Positive	Vegative / IInh	10wn
Please circle yes or no to each item: Yes / No				III V Status	CHOIC, 1 Damie / 1	108411167 07110	TWEET THE PERSON NAMED IN COLUMN TWO
Yes/No Blood Thinners Yes/No Nitroglycerin Yes/No Tranquilizers Yes/No Cortisone Yes/No Other Yes/No Other Yes/No Other If you are taking medication, please list dosages: Are you currently being treated for any of the following: Yes/No Swollen Ankles Yes/No Swollen Ankles Yes/No Shortness of Breath Yes/No High blood pressure Yes/No Heart Murmur, "Leaky valve" Yes/No Anemia Yes/No Diabetes Yes/No Sickle cell anemia, trait Yes/No Hepatitis, Liver disease Yes/No Epilepsy, Convulsions Yes/No Asthma/Lung disease Yes/No Radiation Therapy Yes/No Radiation Therapy Yes/No Widney/Bladder disorder Yes/No Venereal disease Yes/No Do you have any allergies? (drug allergy Yes/No Angina Yes/No Valve damage, valve replacement				Please circle	e ves or no to each	item:	
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Yes / No Valve damage, valve replacement							
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Is there any additional information that you would like the doctor to know? (Please use space below)	Yes / No	Valve damage, valve replacer	nent				
	Is there any add	litional information that you wou	ıld like the doct	or to know? (P	lease use space be	low)	
							X.
	ē1						

Signature

Date