PATIENT MEDICAL INFORMATION

Please Print Clearly on line above items

PATIENT   Date:____________   Referred by:____________________

Last Name   First Name   Middle   Age

Address   City   State   ZIP   Home Telephone

MEDICAL INFORMATION

Yes / No   *Are you currently under a physician's care?*

If yes, explain:

Are you currently taking any of these medications:

Yes / No   Antibiotics
Yes / No   Insulin
Yes / No   Digitalis
Yes / No   Blood Thinners
Yes / No   Nitroglycerin
Yes / No   Tranquilizers
Yes / No   Cortisone
Yes / No   High blood pressure medication
Yes / No   Other__________________

If you are taking medication, please list dosages:

Are you currently being treated for any of the following:

Yes / No   Heart disease
Yes / No   Swollen Ankles
Yes / No   Shortness of Breath
Yes / No   Heart Murmur, "Leaky valve"
Yes / No   High blood pressure
Yes / No   Low blood pressure
Yes / No   Angina
Yes / No   Valve damage, valve replacement

Yes / No   *Have you ever been hospitalized or had surgery?*

If yes, when and why? __________________

HIV Status (circle) *Positive / Negative / Unknown* ________

Please circle yes or no to each item:

Yes / No   Pregnancy - if yes, what month? _______
Yes / No   Prolonged bleeding, bleeding disorders
Yes / No   Anemia
Yes / No   Diabetes
Yes / No   Sickle cell anemia, trait
Yes / No   Hepatitis, Liver disease
Yes / No   Immune deficiency
Yes / No   Epilepsy, Convulsions
Yes / No   Asthma / Lung disease
Yes / No   Contact lenses
Yes / No   Tuberculosis
Yes / No   Radiation Therapy
Yes / No   Rheumatic Fever
Yes / No   Kidney / Bladder disorder
Yes / No   Venereal disease

Yes / No   *Do you have any allergies?*   (drug allergies)

If yes, please list:

Is there any additional information that you would like the doctor to know? (Please use space below)

I certify that the information above is correct and I am not withholding any pertinent medical information.

Signature   Date