MEDICAL HISTORY

DATE _____

ALLERGIES _____

_____

MEDICATIONS AND DOSE (PRESCRIPTION AND OVER THE COUNTER)

_____

_____

SURGERIES (INCLUDE YEAR IF POSSIBLE) _____

_____

_____

HAVE YOU HAD ANY OF THE FOLLOWING? IF **YES** PLEASE EXPLAIN.

NO YES DIABETES _____
NO YES HEART CONDITION _____
NO YES LUNG DISEASE _____
NO YES KIDNEY DISEASE _____
NO YES THYROID CONDITION _____
NO YES CANCER _____
NO YES STROKE OR TIA_____
NO YES HIGH BLOOD PRESSURE _____
NO YES DEPRESSION _____
NO YES CHRONIC PAIN _____
NO YES MIGRAINES _____

ANY OTHER MEDICAL PROBLEMS OR CONDITIONS NOT LISTED ABOVE _____

_____

_____

DAILY SMOKING AMT. _____

ALCOHOL AMT. _____

SIGNATURE OF PATIENT OR GUARDIAN _____