DATE: _____ NAME: _____

DATE: OF BIRTH: _____ AGE: _____

EDUCATION: Years in High School _____ Years in College _____ Post Graduate School _____

MEDICATIONS:

Medicines	Dosage	Medicines	Dosage
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

ALLERGIES: (Circle if you are allergic to)
Penicillin, Sulfa, Iodine, Codeine, Morphine, Demerol, Cephalosporin, Other: _____

SURGERIES: List any surgeries that you have had and the date.

1. _____
2. _____
3. _____
4. _____

PERSONAL HISTORY: (Circle if you have ever had)

1. HEART:
   - Heart Attack
   - Congestive Heart Failure
   - Angina/Chest Pains
   - Angioplasty
   - Rheumatic Heart Fever
   - Atrial Fibrillation
   - Other (explain)
2. LUNGS:
   - TB
   - Emphysema
   - COPD
   - Asthma
   - Other (explain)
3. KIDNEY:
   - Renal Failure
   - Kidney Stones
   - Other (explain)
4. LIVER:
   - Hepatitis
   - Cirrhosis
   - Jaundice
5. GI:
   - Crohn's
   - GERD
   - Ulcerative Colitis
   - Peptic Ulcer
6. OTHER:
   - Stroke
   - Epilepsy/Seizures
   - High Blood Pressure
   - Diabetes
   - Rheumatoid Arthritis
   - Peptic Ulcer Disease
   - Hypothyroid
   - Hyperthyroid
   - Degenerative Arthritis

SYSTEMS: Do you now have

	Yes	No		Yes	No
Any eye disease, injury, impaired sight			Dizziness		
Any ear disease, injury, impaired hearing			Clinical depression		
Loss of consciousness			Hallucinations		
Convulsions			Enlarged thyroid or goiter		
Paralysis			Chronic or frequent cough		
Spitting up of blood			Bladder disease		
Night sweats			Shortness of breath		
Albumin, sugar, pus, etc in urine			Abnormal thirst		
Extreme weakness			Gallbladder disease		
Severe Constipation			Bleed or bruise easily		

Has there been any recent change in: Appetite or eating habits: _____ Bowel or stools? _____

If so, please explain _____

SEE OVER →