

Name \_\_\_\_\_ Date \_\_\_\_\_

I am Allergic to the following medicines: \_\_\_\_\_ NONE

- 1. \_\_\_\_\_ nature of reaction \_\_\_\_\_
- 2. \_\_\_\_\_ nature of reaction \_\_\_\_\_
- 3. \_\_\_\_\_ nature of reaction \_\_\_\_\_

I have (or have had) the following medical problems (please circle) \_\_\_\_\_ NONE

- |              |              |                     |                           |        |
|--------------|--------------|---------------------|---------------------------|--------|
| Diabetes     | Hepatitis    | Heart Failure       | Heart Attack              | Stroke |
| Asthma       | HIV Positive | Gout                | Irregular Heart Rate      |        |
| Seizures     | A.I.D.S      | Kidney Stones       | Cancer of: _____          |        |
| Tuberculosis | Angina       | High Blood Pressure | Substance abuse of: _____ |        |

Currently I have problems with my: \_\_\_\_\_ NONE

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> General health, e.g. weight loss | <input type="checkbox"/> Nervous system   | <input type="checkbox"/> Digestive system           |
| <input type="checkbox"/> Eyes                             | <input type="checkbox"/> Urinary system   | <input type="checkbox"/> Mental health              |
| <input type="checkbox"/> Ears, nose, mouth or throat      | <input type="checkbox"/> Skin or breasts  | <input type="checkbox"/> Glands or hormones         |
| <input type="checkbox"/> Heart or blood vessels           | <input type="checkbox"/> Blood or lymph system                                    | <input type="checkbox"/> Allergies or immune system |
| <input type="checkbox"/> Breathing                        | <input type="checkbox"/> Musculoskeletal other than my reason for coming in today |   |

Please describe the nature of the problem for any checked items above: \_\_\_\_\_

I have had the following surgical procedures performed: \_\_\_\_\_ NONE

- |                             |                             |
|-----------------------------|-----------------------------|
| Year _____, Operation _____ | Year _____, Operation _____ |
| Year _____, Operation _____ | Year _____, Operation _____ |

Other Hospitalizations include: \_\_\_\_\_ NONE

- |                          |                          |
|--------------------------|--------------------------|
| Year _____ Problem _____ | Year _____ Problem _____ |
| Year _____ Problem _____ | Year _____ Problem _____ |

I currently take the following medications (please include over the counter and herbal medicines) \_\_\_\_\_ NONE

- 1. \_\_\_\_\_ 4. \_\_\_\_\_ 7. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_ 8. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_ 9. \_\_\_\_\_

**Social History**

I smoke: \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ # of packs of cigarettes per day,  
 I drink: \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ # glasses of an alcoholic beverage daily, or \_\_\_\_\_ # weekly.  
 My height is \_\_\_\_\_ ft, \_\_\_\_\_ inches. My weight is \_\_\_\_\_ pounds.  
 My favorite hobby is \_\_\_\_\_.  
 If female, date of last menstrual period. \_\_\_\_\_

Family History: The following illnesses are present in parents or siblings: \_\_\_\_\_ NONE

\_\_\_\_\_