CHART # : _____ **NAME:** _____**DATE:**_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING - PLEASE CHECK ALL THAT APPLY

[ ] ALLERGIES TO MEDICATIONS (please list) : _____

[ ] ANEMIA
[ ] ASTHMA
[ ] LUNG PROBLEMS
[ ] THYROID PROBLEMS
[ ] KIDNEY PROBLEMS
[ ] CANCER
[ ] MENTAL DISORDER
[ ] JOINT REPLACEMENT (hip, knee, etc.)

[ ] HIGH BLOOD PRESSURE
[ ] ABNORMAL BLEEDING
[ ] BLOOD PROBLEMS
[ ] DIABETES
[ ] RECENT WEIGHT LOSS
[ ] HEPATITIS-JAUNDICE
[ ] ARTHRITIS

[ ] STROKE
[ ] HEART PROBLEMS (murmurs, valve repair, stents, rheumatic fever, etc.)
[ ] VENERAL DISEASE [VD]
[ ] HIV POSITIVE/AIDS
[ ] TUBERCULOSIS [TB]
[ ] SEIZURES-EPILEPSY
[ ] ARE YOU PREGNANT
[ ] OTHER _____

NAME, ADDRESS & PHONE NUMBER OF PRIMARY MEDICAL DOCTOR: _____

I AM TAKING THE FOLLOWING MEDICATIONS: (INCLUDE OVER THE COUNTER AND HERBAL PRODUCTS)

DRUG NAME?	STRENGTH?	DOSAGE?	HOW OFTEN/WHEN?	WHAT IS IT FOR?