Allergies

____Medications:_____

____Tapes: ____Anesthetics____ Silver/Nickel/Costume Jewelry___ Other_____

What types of reactions have you experienced? _____

_____

Medications

Please list all prescription and over-the-counter medications and dosages:

_____ _____

_____ _____

_____ _____

_____ _____

Surgical History

_____ _____

_____ _____

_____ _____

Health Review

General: ____Fever ____Chlls ____Fatigue ____Weight Loss ____Weight Gain

Head: ____Headaches____Visual Problems __Hearing Problems____Light Sensitivity

Hematology: ____Anemia Abnormal Bleeding/Bruising____Blood Clots

Respiratory: ____Persistent Cough ____Wheezing ___Shortness of Breath

Gastrointestinal: ___Difficulty swallowing ___Indigestion/Heartburn

____Abdominal Pain ____Change in bowel habits

Health Review(cont.)

Urinary: ____Painful Urination ____Frequent Urination____Bladder Leakage

Musculoskeletal: ____Joint pain/Swelling/Stiffness ____Back Pain ___Arthritis

____Muscle Weakness

Skin: ____Skin Rash ____Suspicious Lesions ___Itching

Neurological: ____Numbness of hands/feet ____Seizures ____Tremors

____Paralysis

Endocrine: ____Heat/Cold Intolerance ____Hot Flashes ____Changes in skin

Personal Medical History

____Frequent Headaches/Migraines ____Anemia/Blood Disorders ____Stroke

____Rheumatic Fever ____Pneumonia ____Arthritis

____Kidney Disease ____Drug/Alcohol Abuse ____Chest Pain

____Dialysis ____Epilepsy/Seizures ____Tension

____Diabetes ____Prolonged Bleeding Time ____BLOOD CLOTS

____Tuberculosis ____Stomach Disorder/Ulcer

____Ear/Nose/Throat Disorder

____Emphysema ____ Thyroid/Parathyroid Disease ____Prostate Disorder

____Heart Trouble ____High Blood Pressure ____HIV/AIDS

____Hepatitis ____Asthma/Hay Fever/Shortness of Breath

Smoking Status: ____Never ____Former ____Current # of packs per day:____

Signature: _____ Date:_____