Medical Information

Primary Care Physician_____

Phone Number _____

Date last seen_____

Medical History

__ AIDS/HIV positive
__ Headaches
__Anaphylaxis
__Anemia
__Arthritis, Osteo, rheumatoid
__ Asthma
__Back problems
__ Blood disorder
__ Blood clot, DVT, PE
__Cancer, type_____
__Cholesterol problems
__ Chemotherapy
__ Circulation problems
__ Cough
__ Diabetes
__ Epilepsy
__ Fainting

__ Glaucoma
__ Neuropathy/nerve damage
__ Heart disease, CAD, aneurysm
__Herpes/Venereal Disease
__ Hepatitis, A, B, C
__ Hypertension
__ Kidney disease
__ Liver disease
__ Psychiatric/Depression
__ Respiratory Disease/COPD
__ Seizures
__ Shingles
__ Skin rash
__ Stomach problems/GERD
__ Stroke
__ Thyroid disease
__ Tuberculosis

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