Your Medical Information is Important to Us. Name:______________________________ Date:___________

Do you have any health issues? □ No □ Yes If yes, please circle:

Anemia	Heart Murmur	Melanoma	Phlebitis
Anxiety Disorder	Heart Valve Condition	Multiple Sclerosis	Psoriasis
Asthma	Hepatitis	Neuropathy	Seizures
Back Pain	High Cholesterol	Osteoporosis	Stomach Ulcer
Diabetes	Hypertension	Pacemaker	Stroke
Gout	Hypothyroidism	Parkinson's	
Heart Disease	Kidney Problems	Poor Leg Circulation	

Other:____

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Please list your medications, including OTC and vitamins: (We will be glad to copy your medications list)

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Do you have any allergies to any medicines or other chemicals? □ No □ Yes If yes, please circle:

Adhesive tape	Codeine	Novocaine	Seafoods
Anesthesia	Demerol	Advil/Motrin	Sulfa drugs
Aspirin	Iodine	Penicillin	Neosporin
Ceftin/Keflex	Latex	Augmentin	Glove Powder

Other:____

Have you recently had any of the following surgeries? □ No □ Yes If yes, provide date and explain:

Skin cancer________________________________ Kidney___________________________________

Heart_____________________________________ Leg Bypass for circulation_____________________

Joint replacement/s__________________________ Stomach__________________________________

Other:____

____

Does your family have a history of any of the following? If yes, fill in mother, father, sibling, etc.

Diabetes ____________________ Heart Disease ____________________ Rheumatoid Arthritis _________

Muscle disease _______________ Skin cancer______________________ Psoriasis __________________

Pharmacy Name, Address & Phone Number:____

Primary Doctor's Name & Address:____

Primary Doctor's Phone #:_________________________________ **Date Last Seen**:____________________

Referring Doctor's Name, Phone # & Address ____