

# MEDICAL INFORMATION

Please answer all questions by circling the right answer below.

**CONCERNING ALLERGIES (if yes, please list all)**

DO YOU HAVE AN ALLERGY TO:

- Medications or drugs YES NO
- Ointments, creams or lotions YES NO
- Make-up or jewelry YES NO
- Insect bites YES NO
- Other: YES NO

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**DO YOU OR ANYONE IN YOUR FAMILY SUFFER FROM:**

- Hayfever YES NO
- Asthma YES NO
- Sinus problems YES NO
- Eczema YES NO

*(If yes, specify who has it.)*

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**CONCERNING THE HEART AND VASCULAR SYSTEM**

DO YOU HAVE A HISTORY OF:

- Heart disease YES NO
- Blood pressure problems YES NO
- Abnormal heart beat YES NO
- Heart pacemaker YES NO
- Heart murmurs YES NO
- Rheumatic valve disease YES NO

**CONCERNING YOUR LUNGS**

DO YOU HAVE A HISTORY OF:

- Bronchitis YES NO
- Emphysema YES NO

**CONCERNING YOUR INTERNAL ORGANS**

DO YOU HAVE A HISTORY OF:

- Stomach ulcers YES NO
- Bowel disease YES NO
- Liver disease YES NO
- Diabetes YES NO
- Kidney disease YES NO
- Bladder infections YES NO
- Vaginal infections YES NO
- Prostatic disease or infections YES NO
- Thyroid disease YES NO
- Venereal disease YES NO

**CONCERNING YOUR NERVES**

DO YOU HAVE A HISTORY OF:

- Seizures YES NO
- Migraine headaches YES NO
- Depression YES NO
- Others: YES NO

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**CONCERNING YOUR BLOOD**

DO YOU HAVE A HISTORY OF:

- Anemia YES NO
- Bleeding problems YES NO
- Sickle cell disease YES NO

**CONCERNING YOUR SKIN**

DO YOU HAVE A HISTORY OF:

- Skin cancer YES NO
- Lupus YES NO
- Dermatomyositis YES NO
- Connective tissue disease YES NO
- Other skin diseases YES NO

*(If yes, please list below.)*

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**CONCERNING YOUR FAMILY**

HAS ANYONE IN YOUR FAMILY HAD:

- Heart disease YES NO
- Diabetes YES NO
- Skin cancer YES NO
- Other cancers: YES NO

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**CONCERNING YOUR SOCIAL ACTIVITIES**

- Do you drink alcoholic beverages? YES NO

*(If yes, how many drinks a day?)*

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- Do you smoke? YES NO

*(If yes, how much?)*

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**Please list the name of any medication you are currently taking (including vitamins and birth control pills).**

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**Please list the name and approximate date of any operation you have had.**

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**Date of: illness (first symptom), or injury (accident), or pregnancy (LMP)**

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PRINT NAME

SIGNATURE

DATE