

# 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 & 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), injury (accident) or pregnancy (LMP)

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PRINT NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_