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	Pace Maker	Stroke
Gout	Hypothyroidism	Parkinson's	
Heart Disease	Kidney Problems	Poor Leg Circulation	

Other:_____

_____

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

_____

_____

_____

_____

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 _____