

ALLERGIES:

List All Medicine Allergies:	

Allergic to X-Ray Dye:	Yes		No		No Prior Experience		
Reaction:							

MEDICATIONS:

Medication:	Dose:	Times Per Day:

*If space is insufficient to list all medications, please attach or bring a list of all current medications with you on your next visit

FAMILY HISTORY:

Diabetes:	Yes		No		Family Member:					
Heart Failure:	Yes		No		Family Member:					
Coronary Artery Disease:	Yes		No		Family Member:		Alive?	Yes		No
Stroke:	Yes		No		Family Member:					
Atrial Fibrillation:	Yes		No		Family Member:					
High Cholesterol:	Yes		No		Family Member:					
Thrombophlebitis:	Yes		No		Family Member:					
Blood Clots:	Yes		No		Family Member:					

FAMILY HISTORY (continued):

Father:	Living		Age		Health:
	Deceased		Age		Cause of Death:
Mother:	Living		Age		Health:
	Deceased		Age		Cause of Death:
Sisters:	#	Health:			
Brothers:	#	Health:			
Sons:	#	Health:			
Daughters:	#	Health:			

Personal Health History:

High Blood Pressure:	Blood Transfusion:
High Cholesterol:	Hepatitis:
Diabetes:	Prostate Problem:
Stroke/TIA:	Arthritis:
Heart Rhythm Abnormality:	Gout:
Heart Attack:	Thyroid Disease:
Heart Murmur:	Cancer:
Enlarged Heart:	Rheumatic Fever:
Seizures:	Blood Clots in Legs or Lungs:
Asthma/COPD/Lung Disease:	SYMPTOMS:
Kidney Disease:	Chest Pain:
Bladder Disease:	TIA'S:
Menstruating:	Shortness of Breath:
Ulcers:	Cough, Swelling or Edema:
Diverticulitis:	Pain in Legs During Walking:
Anemia:	Fainting:
Bleeding Problems:	Palpitations:
Blood Transfusion:	Anxiety:
Hepatitis:	Depression:

*If space is insufficient to list all history and symptoms, please attach or bring a list with you on your next visit