

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