MEDICAL HISTORY

Name and address of your regular physician _____ .

_____ .

Approximate date of last visit with your regular physician_____.

Please list conditions for which you are now under treatment, or treat yourself. _____

_____

_____

Medications you are presently taking including herbs, nutritional supplements and/or diet pills:

_____

_____

_____

Do you smoke cigarettes or consume alcohol? If so, how much: _____

Allergies - Please list Medicine Allergies

_____

_____

_____

_____

Other Allergies

_____

_____

_____

_____

Penicillin? _____ Kidney Dye? _____

If needed, will you accept a blood transfusion? _____ Blood Products? _____

Are you now, or have you in the past six months received any treatment from an alternative care provider (chiropractor, acupuncture, etc.).

If so, please list: _____

_____

PREVIOUS SURGERIES - _____

_____

_____

PREVIOUS HOSPITALIZATIONS, NON SURGICAL - Please list the reason for hospitalization and year.

_____

_____

_____

_____

_____

_____

Diagnosis: _____

_____