

Name \_\_\_\_\_ Date \_\_\_\_\_

**I AM ALLERGIC TO THE FOLLOWING MEDICINES:** \_\_\_\_\_ **NONE**

1. \_\_\_\_\_ nature of reaction \_\_\_\_\_

2. \_\_\_\_\_ nature of reaction \_\_\_\_\_

3. \_\_\_\_\_ nature of reaction \_\_\_\_\_

**I HAVE THE FOLLOWING MEDICAL PROBLEMS:** \_\_\_\_\_

**I HAVE HAD THE FOLLOWING (please circle) \_\_\_\_\_ NONE**

Diabetes      Hepatitis      Heart Failure      Heart Attack      Angina

High bld Press      HIV Positive      Irregular Heart Rate      Asthma      Gout

Cancer of      A.I.D.S      Kidney Stones      OTHER: \_\_\_\_\_

Tuberculosis      Stroke      Seizures      Substance abuse of: \_\_\_\_\_

**I HAVE HAD THE FOLLOWING SURGICAL PROCEDURES:** \_\_\_\_\_ **NONE**

Year \_\_\_\_\_, Operation \_\_\_\_\_ Year \_\_\_\_\_, Operation \_\_\_\_\_

Year \_\_\_\_\_, Operation \_\_\_\_\_ Year \_\_\_\_\_, Operation \_\_\_\_\_

**OTHER HOSPITALIZATIONS INCLUDE:** \_\_\_\_\_ **NONE**

Year \_\_\_\_\_ Problem \_\_\_\_\_ Year \_\_\_\_\_ Problem \_\_\_\_\_

Year \_\_\_\_\_ Problem \_\_\_\_\_ Year \_\_\_\_\_ Problem \_\_\_\_\_

**I CURRENTLY TAKE THE FOLLOWING MEDICATIONS \_\_\_\_\_ NONE**

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

**I CURRENTLY TAKE THE FOLLOWING HERBAL MEDICINES:** \_\_\_\_\_

**I currently take the following substances containing EPHEDRA** \_\_\_\_\_

#### **SOCIAL HISTORY**

I smoke \_\_\_\_\_ packs of cigarettes per day, I have \_\_\_\_\_ glasses of an alcoholic beverage daily, or \_\_\_\_\_ glasses weekly. My height is \_\_\_\_\_ ft, \_\_\_\_\_ inches. My weight is \_\_\_\_\_ pounds. My favorite hobby is \_\_\_\_\_.

**FAMILY HISTORY:** The following illnesses are present in parents or siblings: \_\_\_\_\_ **NONE**

**REVIEW OF SYSTEMS:** Currently I have problems with my: \_\_\_\_\_ **NONE**

\_\_\_ general health, e.g. weight loss

\_\_\_ nervous system

\_\_\_ eyes

\_\_\_ mental health

\_\_\_ ears, nose, mouth or throat

\_\_\_ glands or hormones

\_\_\_ heart or blood vessels

\_\_\_ blood or lymph system

\_\_\_ breathing

\_\_\_ allergies or immune system

\_\_\_ digestive system

\_\_\_ other

\_\_\_ urinary system

\_\_\_ musculoskeletal other than my reason for

\_\_\_ skin or breasts

coming in today

Please describe the nature of the problem for any checked items above:

\_\_\_\_\_