Patient Information

Name: ______________________________ **Date:** ______________________

Are you under a doctor's care now? Yes______ No______

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Are you taking any drugs or medications now? Yes______ No______

If yes, please list the names and dose of the medication you are currently taking:

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If you have ever been treated for the following, please circle the condition:

Tumor or Cancer
Convulsions
Fainting Spells
Disabling Headaches
Nervous Disorder
Skin Rash
Goiter or Thyroid Trouble
Diabetes
Asthma
Tuberculosis
Pneumonia
Shortness of Breath
Coughed up Blood
Chest Pain
Heart Murmur
Blood Pressure Trouble
Rheumatic Fever
Heart Trouble
Blood Disease or Anemia
Blood Clots
Jaundice
Liver Disease
Gallbladder Trouble
Stomach Trouble or Ulcer
Rectal Bleeding
Kidney Trouble
Blood in Urine
Albumen or Sugar in Urine
Arthritis
"Trick" or Locked Joint
Broken Bone
Dislocation
Back Disorder
Disc Trouble
Paralysis or Muscle Weakness
Foot Trouble
Calf Pain

Please explain the details for all items you circled. If necessary, use the back of this page for further information:

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<u>List all Previous Surgery:</u> **<u>Year:</u>** **<u>Name of Physician:</u>**

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