PLEASE CHECK THE BOX FOR ANY DISEASE WHICH YOU WERE PREVIOUSLY DIAGNOSED.

☐ AIDS/HIV	☐ DEPRESSION	☐ HYPERTENSION	Recent Hospitalizations:_____
☐ ALCOHOLISM	☐ DIABETES	☐ KIDNEY DISEASE	Recent MRI's,CT's, X-rays: _____
☐ ALZHEIMERS	☐ DRUG ABUSE	☐ OSTEOARTHRITIS	Recent Bloodwork:_____
☐ ANEMIA	☐ HIGH CHOLESTEROL	☐ OSTEOPOROSIS	
☐ ARTHRITIS	☐ EYE DISEASE	☐ PACEMAKER	
☐ ASTHMA	☐ FIBROMYALGIA	☐ SEIZURES	
☐ BLEEDING DISORDER	☐ GI REFLUX	☐ SLEEP APNEA	
☐ BLOOD CLOTS	☐ GOUT	☐ STROKE	
☐ CANCER	☐ HEART DISEASE	☐ THYROID DISEASE	
☐ COPD	☐ HEPATITIS	☐ ULCERS	

Other:_____

_____

_____

LIST OF ALL CURRENT MEDICATIONS, INCLUDING OVER-THE-COUNTER DRUGS, VITAMINS, SUPPLEMENTS AND THEIR USE

DRUG NAME	DOSE/STRENGTH	FREQUENCY	REASON

ALLERGIES

☐ NONE KNOWN ☐ CODEINE ☐ PENICILLIN ☐ IODINE ☐ SULFA ☐ DEMEROL