Name: _____ Social Security Number: _____

Referring Doctor: _____ _____ Age: _____ Date: _____

Reason for <u>Current</u> visit:

_____

_____

_____

_____

Are you **<u>Allergic</u> or <u>Sensitive</u>** to any medications, latex or radiographic dye? (List **<u>ALL</u>** medication and reactions)

□ I have no allergies _____ _____

_____ _____ _____

List all medications and dosages you currently take. (Including Supplements)

□ I take no medications _____ _____

_____ _____ _____

Past medical and surgical history:
Check all that apply.

□ Anemia	□ Depression	□ High Cholesterol	□ Phlebitis
□ Arthritis	□ Diabetes	□ Hypertension	□ Prostate Cancer
□ Asthma	□ Emphysema	□ Irregular Rhythm	□ Stroke
□ Bladder Cancer	□ Gastritis/Ulcer	□ Kidney Cancer	□ Thyroid Disease
□ Cirrhosis	□ Heart Attack	□ Kidney Stones	□ Urine Infections
□ Cancer (List) _____ _____	□ Heart Murmur	□ Multiple Sclerosis	□ Vascular Disease
	□ Hepatitis	□ Parkinson's	□ Venereal Disease

□ Other _____ _____ _____

□ I have no medical problems

List all your operations (Including dates) (Example: Hernia repair 1991, ect)

□ I have had no surgery _____ _____

_____ _____ _____