Medical Conditions

Name:_____ Date: _____

Allergies: _____

Cardiovascular: Heart Attack Bypass Stents Irregular Heartbeat Atrial Fibrillation Pacemaker Angina High Blood Pressure Other _____

Neurological: Stroke Seizures Memory Loss Paralysis Migraine Headaches Multiple Sclerosis Other _____

Respiratory: Asthma COPD Chronic Bronchitis Persistent Cough Other _____

Endocrine: Diabetes Hyperthyroid Hypothyroid Graves' disease Other _____

Ear, Nose, Throat: Sinusitis Hearing Loss Other _____

Gastrointestinal: Reflux Ulcers Ulcerative Colitis Crohn's disease Liver Disease Other_____

Genitourinary: Kidney Disease Kidney Stones Enlarged Prostate Incontinence Other _____

Musculoskeletal: Arthritis Joint Replacement Fibromyalgia Other _____

Psychiatric: Depression Anxiety Bipolar Schizophrenia Other _____

Skin: Rash Eczema Shingles Lupus Cold Sores Rosacea Other _____

Metabolic: High Cholesterol High Triglycerides

Hematologic/Lymphatic: Anemia Low White Cells Low Platelets Leukemia Lymphoma HIV+ Other _____

Cancer: Please indicate type of cancer _____

Smoking History: Never; Stopped _____ years ago; smoke ___ packs per day

Currently Pregnant: (circle one) Yes No N/A

Surgery: List previous operations within the last five years.