

Medical Information Form

Patient Information			
First Name Jim	Last Name Johnson	Date of Birth 17/04/1976	Gender Male
Section One			
Are you pregnant or trying to get pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable			
Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable			
Are you taking any medication? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain: Frusemide			
Do you use any tobacco? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain how often and how long have you been using them: yes. About 2 packs (20cig) every week, since i was 16			
Do you use any controlled substances? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain what types of substances do you take, how often and how long have you been taking them: weed couple times a month. About a gram each month, since i was 20			
Do you have any allergies? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain what you are allergic to, and what is the allergic reaction like: Amoxicillin			
Section Two			
Do you have, or have you had, any of the following?			
<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Anemia	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> Angina	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis Gout	<input type="checkbox"/> Emphysema	<input checked="" type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Shingles
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting/Syncope	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Frequent Diarrhea	<input checked="" type="checkbox"/> Kidney Problems	<input type="checkbox"/> Stomach Disease
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Chest Pain	<input checked="" type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Mitral valve Prolapse	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Venereal Diseases
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Jaundice