Date: **Patient Name/ID#:** **M F DOB:**

Are you allergic to any medications? **Yes/No** **If yes, please list**

Medication:	**Reaction:**

Please list medications you are currently taking. (Include over-the-counter)

Current Medications:	**Dosage**	**Frequency**	**Reason:**

Indicate if you have or have had any of the following by entering the approximate date of diagnosis. (If date of diagnosis is unknown, please indicate the approximate date of onset)

Illness	**Date (mm/yy if known)**	Illness	**Date (mm/yy if known)**
AIDS/HIV		Hepatitis, type:	
Anemia		High blood pressure	
Alcoholism		High cholesterol	
Allergies (other than meds)		Kidney disease	
Anorexia/bulimia		Liver disease	
Appendicitis		Lung disease	
Arthritis		Measles	
Asthma		Migraine headaches	
Cancer		Mononucleosis	
Chemical dependency		Mumps	
Chickenpox		Pneumonia	
Depression		Psychiatric care	
Diabetes		Rheumatic Fever	
Emphysema		Rubella	
Epilepsy/convulsions		Sexually transmitted disease	
Frequent kidney or bladder infection		Stomach ulcer	
Frequent lung infection		Stroke	
Gallbladder disease		Thyroid problems	
Gout		Tonsillitis	
Glaucoma, eye disease		Tuberculosis	
Heart Disease		Whooping Cough	

Enter full date, if known (mmdd/yy)

Surgeries:	**Date**	**Other Hospitalizations:**	**Date**

Other significant illnesses or injuries (please list):	**Date**