Medical Information

1. Do you have any Allergies? If yes, please specify**.** **Yes** **No**

   _____

   _____

2. Are you currently taking any medications? If yes, please specify. **Yes** **No**

   _____

   _____

3. Have you ever had any Major Surgery? If yes, please specify type(s). **Yes** **No**

   _____

   Approximate Date(s) _____

4. Do you have Artificial Hips, Knees, or any other joints? **Yes** **No**
5. Have you been told you needed a PRE-MED? If yes, please specify. **Yes** **No**

   _____

   Approximate Date of Surgery:_____

6. Have you ever taken any medication to treat obesity, bone disease, or stroke? **Yes** **No**
7. Are you on a special diet? **Yes** **No**
8. Are you pregnant? **Yes** **No** **8.** Taking oral Contraceptives **Yes** **No**

Do you have, or have had, any of the following?

__AIDS/HIV Positive
__Alzheimer's Disease
__Anaphylaxis
__Anemia
__Angina
__Arthritis
__Artificial Heart Valve
__Asthma
__Blood Disease
__Blood Transfusion
__Breathing Problem Hay Fever
__Bruise Easily
__Cancer
__Chemotherapy
__Cold Sores/Fever Blisters
__Convulsions
__Congenital Heart Disorder
__Cortisone Medicine
__Diabetes
__Drug Addiction
__Easily Winded
__Excessive Thirst
__Excessive Bleeding
__Emphysema
__Epilepsy or Seizures
__Fainting/Dizziness
__Frequent Cough
__ Frequent Diarrhea
__ Frequent Headaches
__ Genital Herpes
__ Glaucoma
__ Gout/ Chest Pains
__Heart Attack/Failure
__Heart Murmur
__Heart Trouble/Disease
__Hemophilia
__Hepatitis A,B,C
__Herpes
__High Blood Pressure
__Hives or Rash
__Hypoglycemia
__Irregular Heartbeat
__Jaw pain
__ Kidney Problems
__Leukemia
__Liver Disease
__Low Blood Pressure
__Lung Disease
__Mitral Valve Prolapse
__Osteoporosis/Bone Disease
__Parathyroid Disease
__Psychiatric Care
__Radiation Treatments
__Recent weight loss
__Renal Dialysis
__Rheumatoid Arthritis
__Rheumatic Fever
__Shingles
__Sickle Cell Disease
__Sinus Trouble
__ Spina Bifida
__Stomach Disease
__Stroke
__Swelling Limbs
__Tonsillitis
__Thyroid Disease
__Tuberculosis
__Tumors
__Yellow Jaundice

Other Please Explain:_____

_____

Name and phone number of your physician: _____

Name and Number to call in the event of an emergency: _____

Signature: _____ ***Date:*** _____