

Patient Medical Information

Allergic to:

<input type="checkbox"/> Y <input type="checkbox"/> N	Aspirin
<input type="checkbox"/> Y <input type="checkbox"/> N	Barbiturates/ Sleeping Pills
<input type="checkbox"/> Y <input type="checkbox"/> N	Codeine/ Narcotics
<input type="checkbox"/> Y <input type="checkbox"/> N	Erythromycin
<input type="checkbox"/> Y <input type="checkbox"/> N	Gluten
<input type="checkbox"/> Y <input type="checkbox"/> N	Iodine
<input type="checkbox"/> Y <input type="checkbox"/> N	Latex Rubber
<input type="checkbox"/> Y <input type="checkbox"/> N	Local Anesthesia
<input type="checkbox"/> Y <input type="checkbox"/> N	Metals
<input type="checkbox"/> Y <input type="checkbox"/> N	Epinephrine
<input type="checkbox"/> Y <input type="checkbox"/> N	Penicillin
<input type="checkbox"/> Y <input type="checkbox"/> N	Sulfa Drugs
<input type="checkbox"/> Y <input type="checkbox"/> N	Tetracycline
<input type="checkbox"/> Y <input type="checkbox"/> N	Wine/Sulfites (Food Preservatives)
<input type="checkbox"/> Y <input type="checkbox"/> N	Other, Describe:

Check, if applicable:

<input type="checkbox"/> Y <input type="checkbox"/> N	AIDS/HIV
<input type="checkbox"/> Y <input type="checkbox"/> N	Alcohol/ Drug Abuse
<input type="checkbox"/> Y <input type="checkbox"/> N	Acid Reflux
<input type="checkbox"/> Y <input type="checkbox"/> N	Anemia
<input type="checkbox"/> Y <input type="checkbox"/> N	Ankles Swell
<input type="checkbox"/> Y <input type="checkbox"/> N	Anorexia/Bulimia
<input type="checkbox"/> Y <input type="checkbox"/> N	Arthritis
<input type="checkbox"/> Y <input type="checkbox"/> N	Asthma
<input type="checkbox"/> Y <input type="checkbox"/> N	Bisphosphonates
<input type="checkbox"/> Y <input type="checkbox"/> N	Blood Clotting Issues
<input type="checkbox"/> Y <input type="checkbox"/> N	Blood Disease
<input type="checkbox"/> Y <input type="checkbox"/> N	Blood Thinners
<input type="checkbox"/> Y <input type="checkbox"/> N	Blood Transfusion
<input type="checkbox"/> Y <input type="checkbox"/> N	Bronchitis

<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer/ Tumor or Growth
<input type="checkbox"/> Y <input type="checkbox"/> N	Cardiac Pacemaker
<input type="checkbox"/> Y <input type="checkbox"/> N	Chemical Dependency
<input type="checkbox"/> Y <input type="checkbox"/> N	Chemotherapy
<input type="checkbox"/> Y <input type="checkbox"/> N	Chest Pain
<input type="checkbox"/> Y <input type="checkbox"/> N	Blindness
<input type="checkbox"/> Y <input type="checkbox"/> N	Cold Sores
<input type="checkbox"/> Y <input type="checkbox"/> N	Contact Lenses
<input type="checkbox"/> Y <input type="checkbox"/> N	Coumadin
<input type="checkbox"/> Y <input type="checkbox"/> N	Damaged Heart Valve
<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes
<input type="checkbox"/> Y <input type="checkbox"/> N	Emphysema
<input type="checkbox"/> Y <input type="checkbox"/> N	Environmental Allergies
<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy
<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting Spells
<input type="checkbox"/> Y <input type="checkbox"/> N	Headaches/Migraines
<input type="checkbox"/> Y <input type="checkbox"/> N	Dry Mouth/Sjogren's
<input type="checkbox"/> Y <input type="checkbox"/> N	Gall Bladder Trouble
<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma
<input type="checkbox"/> Y <input type="checkbox"/> N	Hay Fever
<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Attack
<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Disease/ Angina
<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Murmur
<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Problems
<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis/ Jaundice
<input type="checkbox"/> Y <input type="checkbox"/> N	Herpes
<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N	Hives/ Skin Rash
<input type="checkbox"/> Y <input type="checkbox"/> N	Joint Replacement
<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney/ Bladder Issues
<input type="checkbox"/> Y <input type="checkbox"/> N	Leukemia
<input type="checkbox"/> Y <input type="checkbox"/> N	Liver Disease

<input type="checkbox"/> Y <input type="checkbox"/> N	Low Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N	Mental Health Problems
<input type="checkbox"/> Y <input type="checkbox"/> N	Mitral Valve Prolapse
<input type="checkbox"/> Y <input type="checkbox"/> N	Nervous Problems
<input type="checkbox"/> Y <input type="checkbox"/> N	Pacemaker
<input type="checkbox"/> Y <input type="checkbox"/> N	Persistent Diarrhea
<input type="checkbox"/> Y <input type="checkbox"/> N	Premedicate
<input type="checkbox"/> Y <input type="checkbox"/> N	Prior Hepatitis
<input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric Care
<input type="checkbox"/> Y <input type="checkbox"/> N	Radiation Treatment
<input type="checkbox"/> Y <input type="checkbox"/> N	Respiratory Disease
<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever
<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Heart Disease
<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures
<input type="checkbox"/> Y <input type="checkbox"/> N	Sexually Transmitted Diseases
<input type="checkbox"/> Y <input type="checkbox"/> N	Shortness of Breath
<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Trouble
<input type="checkbox"/> Y <input type="checkbox"/> N	Stomach Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N	Stuffy Nose/Post Nasal Drip
<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid Issues
<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N	Weight Loss (10lbs in 6mths)
<input type="checkbox"/> Y <input type="checkbox"/> N	Urine Frequently
<input type="checkbox"/> Y <input type="checkbox"/> N	Other, Describe: