Name_____ **Date**_____

Put a check mark next to all the conditions which you have or have had in the past

current	past	
☐	☐	allergies, seasonal
☐	☐	anemia
☐	☐	anxiety
☐	☐	arthritis
☐	☐	asthma
☐	☐	atrial fibrillation
☐	☐	angina
☐	☐	back problems
☐	☐	blood clots
☐	☐	cancer
☐	☐	chest pain
☐	☐	carpal tunnel
☐	☐	COPD
☐	☐	depression
☐	☐	diabetes
☐	☐	dry mouth, dry eyes
☐	☐	gall bladder problems
☐	☐	gout
☐	☐	headaches
☐	☐	heartburn
☐	☐	hepatitis A, B or C
☐	☐	high cholesterol
☐	☐	high blood pressure
☐	☐	intestinal problems
☐	☐	irritable bowel
☐	☐	kidney problems
☐	☐	migraines
☐	☐	mouth sores
☐	☐	osteoporosis
☐	☐	prostate problems
☐	☐	seizures
☐	☐	skin problems
☐	☐	stomach ulcers
☐	☐	stroke
☐	☐	thyroid problems

Approximate Year

Angioplasty _____
Appendectomy _____
Arthroscopy _____
Back Surgery _____
Bladder Surgery _____
Breast Implants _____
Carpal Tunnel Release _____
Cataract Surgery R L _____
Gall Bladder Surgery _____
Colectomy _____
Colostomy _____
Gastric Bypass _____
Heart Bypass _____
Hernia Repair _____
Hip Replacement R L _____
Hysterectomy _____
Knee Replacement R L _____
LASIX _____
Liver Biopsy _____
Pacemaker _____
Prostate Surgery _____
Thyroidectomy _____
Tonsillectomy _____
Tubal Ligation _____
TURP _____
Vasectomy _____
Other _____

_____

_____

Have you had any of the following vaccines?

☐ BCG
☐ Hepatitis B