Check if you have had any of the following:

_ Anemia
_ Arthritis, Rheumatism
_ Artificial heart valves
_ Artificial joints, pins,etc
_ Bleeding abnormally
_ Blood disease
_ Cancer
_ Chemical Dependency
_ Chemotherapy
_ Circulatory problems
_ Congenital heart lesions
_ Diabetes
_ Epilepsy
_ Fainting
_ Glaucoma
_ Headaches
_ Heart murmur
_ Hemophilia
_ Hepatitis
_ High Blood pressure
_ HIV AIDS
_ Jaw pain
_ Kidney disease
_ Liver disease
_ Mitral valve prolapse
_ Pacemaker
_ Radiation treatment
_ Respiratory disease
_ Rheumatic fever
_ Scarlet fever
_ Stroke
_ Swelling of feet/ankles
_ Thyroid Problems
_ Tobacco use
_ Tonsillitis
_ Tuberculosis
_ Ulcer

List all medications you are taking

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List Diagnosis

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List All Allergies

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To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child has any change in health.

Signature__________________________________

Date ____________________________

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