Medical History

Please list any medical conditions for which you are currently being treated		

Please list all prior hospitalizations for medical illnesses	
Date	Procedure

Do you have, or have you ever had any of the following?		
High blood pressure	Lung disease	Anemia
Diabetes	Arthritis	GI Problems
Heart disease	Thyroid disease	Liver damage or hepatitis
Asthma	Other endocrine problems	HIV+ or AIDS
Skin disease	Gynecological problems	Neurological Problems
Eye problems	Kidney problems	Seizures
ENT problems	Genital problems	Cancer
Fibromyalgia	Chronic pain	Migraine

Are you allergic to any foods or medications? If so, please list	
Food or medication	Reaction experienced

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