

ALLERGIES, ILLNESSES AND MEDICAL PROBLEMS

YOUR NAME _____ DATE _____

	YES	NO	EFFECT		YES	NO	EFFECT
PENICILLIN	<input type="checkbox"/>	<input type="checkbox"/>	_____	TAPE	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER MEDICATION	<input type="checkbox"/>	<input type="checkbox"/>	_____	HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	FOOD	<input type="checkbox"/>	<input type="checkbox"/>	_____
IODINE	<input type="checkbox"/>	<input type="checkbox"/>	_____	SHELL FOOD	<input type="checkbox"/>	<input type="checkbox"/>	_____
CONTACT ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>	_____	SHELL FOOD	<input type="checkbox"/>	<input type="checkbox"/>	_____

EXPLAIN ALLERGIC EFFECTS: _____

DATE OF LAST TETANUS SHOT: _____

ILLNESS & MEDICAL PROBLEMS:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	BRONCHITIS
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA
<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	PNEUMONIA
<input type="checkbox"/>	<input type="checkbox"/>	OTHER HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	ANESTHESIA PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	DIZZY SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER
<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	COLITIS
<input type="checkbox"/>	<input type="checkbox"/>	OTHER EYE TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	DIVERTICULOSIS
<input type="checkbox"/>	<input type="checkbox"/>	EAR TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS
<input type="checkbox"/>	<input type="checkbox"/>	SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	MONONUCLEOSIS
<input type="checkbox"/>	<input type="checkbox"/>	DEAF OR HEARING IMP.	<input type="checkbox"/>	<input type="checkbox"/>	GALL BLADDER TROUBLE
<input type="checkbox"/>	<input type="checkbox"/>	NOSE BLEEDS	<input type="checkbox"/>	<input type="checkbox"/>	STROKE
<input type="checkbox"/>	<input type="checkbox"/>	NOSE OBSTRUCTION	<input type="checkbox"/>	<input type="checkbox"/>	SLEEP APNEA/DISORDERS
<input type="checkbox"/>	<input type="checkbox"/>	SWELLING IN NECK	<input type="checkbox"/>	<input type="checkbox"/>	CONVULSIONS/SEIZURES
<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	HEALING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY / BLADDER PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	HERNIAS	<input type="checkbox"/>	<input type="checkbox"/>	VARICOSE VEINS
<input type="checkbox"/>	<input type="checkbox"/>	LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	BLEED EASILY
<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	EYE PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	BRUISE EASILY	<input type="checkbox"/>	<input type="checkbox"/>	PARALYSIS
<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	CANCER:
<input type="checkbox"/>	<input type="checkbox"/>	ANKLE SWELL	YEAR / TYPE _____		
<input type="checkbox"/>	<input type="checkbox"/>	MENTAL / NEUROLOGICAL CONDITION:	<input type="checkbox"/>	<input type="checkbox"/>	LUNG PROBLEMS:
		_____	_____		

HAVE YOU HAD A MOLE SCREENING?
DATE: _____

DO YOU HAVE ANY MOLES / BEAUTY MARKS WHICH ARE IREGULAR, MULTI-COLORED, OR HAVE CHANGED?

WOMEN ONLY

<input type="checkbox"/> TENDER BREASTS	<input type="checkbox"/> LUMPS OR OR RECENT SIZE/COLOR CHANGE
<input type="checkbox"/> FIBROCYSTIC DISEASE	PREVIOUS MAMMOGRAM YEAR: _____
<input type="checkbox"/> MENSTRUAL PROBLEM	LAST MENSTRUAL PERIOD: _____
<input type="checkbox"/> WERE YOUR CHILDREN BREAST FED	NUMBER OF CHILDREN: _____
<input type="checkbox"/> DO YOU PLAN TO HAVE CHILDREN?	

HAVE ANY OF THE ABOVE CONDITIONS APPEARED IN YOUR IMMEDIATE FAMILY? IF SO, SPECIFY: