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MEDICAL INFORMATION

Primary physician's name a	nd address				
Complaint (Reason for seeil	ng Dr. Dick				want to read
		PAST ME	EDICAL HISTORY		
Have your ever had surgery	?	YesN	No		Year
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DO YOU HAVE Heart Disease High Blood Pressure Diabetes Epilepsy Thyroid Disease Asthma Kidney Disease Broken Bones Hepatitis Cancer Anemia Bleeding tendency Easy bruising TB Bronchitis Emphysema Shortness of breath ARE YOU ALLERGIC TO: Penicillin Novocaine Other drugs (please list)	YES	80000000000000000000000000000000000000	DO YOU HAVE Chest Pain Dizzy Spells Ulcers Glaucoma Nervous Condition Depression AIDS/HIV HAVE YOUR EVER HAD: Rheumatic fever Cold Sores DO YOU TAKE: Blood thinner medication Heart medication High blood pressure med. Diuretics (water pills) Aspirin Steroids DO YOU SMOKE? Have you smoked in the past? DO YOU DRINK ALCOHOL?	YEOOOOOO OO OOOOOO OOO	2000000 00 000000 000
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