Medical Information

Have You Ever Had and/or Been Treated For The Following?

(PLEASE CHECK THE FOLLOWING THAT APPLY)

HEART: _____ Angina _____ Heart Attack _____ Heart Disease _____ Heart Murmur _____ High Blood Pressure _____ High Cholesterol _____ Mitral Valve Prolapse _____ Pacemaker _____ Stroke

RESPIRATORY: _____ Asthma _____ Emphysema _____ Tuberculousis

ARTHRITIS: _____ Gout _____ Osteroarthritis _____ Rheumatoid Arthritis

VASCULAR: _____ Anemia _____ Blood Clots _____ Foot/ Leg Cramps _____ Leg Pain When Walking _____ Poor Circulation _____ Prolonged Bleeding _____ Stroke _____ Varicose Veins

GASTROINTESTINAL: _____ Acid Reflux (GERD) _____ Bowel Disorders _____ GI/ Rectal Bleeding _____ Hiatal Hernia _____ Stomach Problems _____ Ulcers

NEUROLOGICAL: _____ Epilepsy Seizures _____ Parkinson's Disease

PSYCHOLOGICAL: _____ Anxiety _____ Psychiatric Care _____ Depression

OTHER: ___ Back Problems ___ Bladder Problems ___ Muscle Disease (Polio) ___ HIV ___ Kidney Problems ___ Hepatitis ___ Healing Problems ___ Thyroid Disease ___ Implants ___ Dialysis ___ Frequent Infections ___ Unexplained Weight Loss ___ Cancer

DIABETES: ___ Insulin ___ Non Insulin

FAMILY HISTORY

Adopted? Yes __ No__ If adopted and if you do not know your family history please skip this section. Indicate which relative has had the following diseases(parents, brothers, and sisters are the most important)

Diagnosis

Alcoholism _____ Depression _____ Osteoarthritis _____

Asthma _____ Diabetes _____ Peripheral Vascular Disease _____

Alzheimer's _____ Hypertension _____ Renal Disease _____

Cancer _____ High Cholesterol _____ Seizure Disorder _____

CAD _____ Migraines _____ Mental Illness _____

CVA/Stroke _____ Obesity _____ Other: _____

List of Medications you are taking? For?

_____

_____

Blood Thinners? Name: _____ **Dosage:** _____

Do you take Aspirin on a Daily Basis? Yes ___ No ___

List of any Allergies you may Have and/or Sensitivities?

_____

_____

Do you Smoke? Yes ___ No ___ If YES, How many packs per day? _____

Do you Drink Alcohol? Yes ___ No ___ If YES: Daily ___ Socially ___

Are you Pregnant? Yes ___ No ___

What Surgeries and/or Operations have you had?

_____

_____

I, CERTIFY THIS INFORMATION BEING CORRECT AND WILL NOTIFY DR. CHAPMAN IF ANY CHANGES OCCUR.

Signature: _____ Date: _____