Respiratory		
Tuberculosis	Y	N
Emphysema	Y	N
Asthma/Hay fever	Y	N
Persistent cough	Y	N
Sputum production (phlegm)	Y	N
Cough up bloody sputum	Y	N
Difficulty breathing lying down	Y	N
Allergies	Y	N
Mononucleosis	Y	N
Epstein/Barr	Y	N
Lung disease	Y	N
ENDOCRINE		
Diabetes	Y	N
Family history of diabetes	Y	N
Thyroid condition/goiter	Y	N
Parathyroid	Y	N
Hypoglycemia	Y	N
Bone/Muscles		
Arthritis/Rheumatism	Y	N
Artificial joints	Y	N
Gout	Y	N

Urethral discharge	Y	N
Bloody urine	Y	N
Venereal disease	Y	N
BLOOD		
Bruise easily	Y	N
Anemia	Y	N
Blood transfusion	Y	N

Date_____

T cell count_____

Viral Load_____

HIV+	Y	N
Sickle cell anemia	Y	N
Hemophilia	Y	N
OTHER		
Radiation therapy	Y	N
Tumors or growths	Y	N
Cancer	Y	N
Chemo Therapy	Y	N
Cobalt	Y	N
Herpes	Y	N
Cold Sores	Y	N
Fever blisters	Y	N
Drug Addiction	Y	N

Are you ALLERGIC or have you ever experienced any reaction to the following?

Local anesthetics (Novocaine)	Y	N
Barbiturates/Sedatives/Sleeping pills	Y	N
Penicillin/other antibiotics	Y	N
Aspirin or Codeine	Y	N
Sulfa drugs	Y	N
Other allergies	_____	

Are you taking any of the following? (If yes to any, list the name of medication and dosage.)

Antibiotics/Sulfa drugs	Y	N	_____
Blood thinners	Y	N	_____
Blood pressure medication	Y	N	_____
Thyroid medication	Y	N	_____
Cortisone/Steroids	Y	N	_____
Antihistamines/allergy drugs	Y	N	_____
Cold remedies	Y	N	_____
Tranquilizers	Y	N	_____
Insulin/other diabetic drugs	Y	N	_____
Aspirin	Y	N	_____
Digitalis/other diabetic drugs	Y	N	_____
Nitroglycerin	Y	N	_____
Recreational drugs	Y	N	_____
Other medications	Y	N	_____

8. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain_____

_____

9. Medical Doctor's Name_____Phone #_____