MEDICAL INFORMATION

PATIENT'S NAME:_____

FAMILY DOCTOR:_____

FAMILY DOCTOR'S PHONE NUMBER:_____

CHECK IF YOU HAVE:

DIABETES____	CANCER____	HEPATITIS____
HEART DISEASE____	POOR CIRCULATION____	STROKE____
HIGH BLOOD PRESSURE____	GOUT____	ANEMIA____

NERVE DISORDER____

OTHER:_____

LIST ANY SURGERY:_____

_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

DRINK ALCOHOL DAILY?____ SMOKE?_____

ARE YOU ALLERGIC TO:

PENICILLIN____	ASPIRIN____	SULFA____
ADHESIVE TAPE____	IODINE____	

OTHER_____

_____

The above information is accurate to the best of my knowledge.

SIGNATURE_____ DATE_____