MEDICAL INFORMATION SHEET

1. Do you have a history of any of the following? (Please circle)

   Heart attack or failure
   Irregular heart rhythms
   Strokes or mini-strokes
   High cholesterol
   High blood pressure
   Chest pains
   Diabetes
   Emphysema
   Pain in your legs when you walk
   Kidney failure

2. List any operations you have had: ____________________

   ____

3. List any medications you take on a regular basis: ____________________

   ____

4. List any medicine (s) that you are allergic to? ____________________

5. Do you have a Latex allergy? ____________________

6. List any illnesses/diseases that run in your family? ____________________

   ____

7. Do you smoke? Yes No If so, how much? ____________________

8. Do you drink alcohol? Yes No If so, how much? ____________________

9. Are you on dialysis? Yes No If so, what days? ____________________

   Dialysis center ____________________

   Phone number ____________________

10. Have you had changes in your:

    Vision Hearing Voice Speech Swallowing?

11. Have you had any of these symptoms recently? (Please circle)

    Chest tightness or heaviness
    Decrease in muscle strength or tone
    Impotence
    Difficulty starting urination
    Masses in your neck, armpit, or groin
    Abdominal pain with eating, constipation, or diarrhea
    Shortness of breath
    Nausea and vomiting
    Thyroid problems
    Weight loss
    Painful joints or arthritis

Name ____________________ Date ____________________