# Medical Information Form

## Patient Information

| First Name | Last Name | Date of Birth | Gender |
|---|---|---|---|
| Jim | Johnson | 17/04/1976 | Male |

## Section One

Are you pregnant or trying to get pregnant? ☐ Yes ☐ No ☐ Not Applicable

Are you taking oral contraceptives? ☐ Yes ☐ No ☐ Not Applicable

Are you taking any medication? ☑ Yes ☐ No

If yes, please explain:

Frusemide

Do you use any tobacco? ☑ Yes ☐ No

If yes, please explain how often and how long have you been using them:

yes. About 2 packs (20cig) every week, since i was 16

Do you use any controlled substances? ☑ Yes ☐ No

If yes, please explain what types of substances do you take, how often and how long have you been taking them:

weed couple times a month. About a gram each month, since i was 20

Do you have any allergies? ☑ Yes ☐ No

If yes, please explain what you are allergic to, and what is the allergic reaction like:

Amoxicillin

## Section Two

Do you have, or have you had, any of the following?

| | | | |
|---|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Cortisone Medicine | ☐ Hemophilia | ☐ Psychiatric Care |
| ☐ Alzheimer's Disease | ☐ Diabetes | ☐ Hepatitis A | ☐ Radiation Treatment |
| ☐ Anemia | ☐ Drug Addiction | ☐ Hepatitis B or C | ☐ Renal Dialysis |
| ☐ Angina | ☐ Easily Winded | ☐ Herpes | ☐ Rheumatic Fever |
| ☐ Arthritis Gout | ☐ Emphysema | ☑ High Blood Pressure | ☐ Rheumatism |
| ☐ Artificial Heart Valve | ☐ Excessive Bleeding | ☐ High Cholesterol | ☐ Scarlet Fever |
| ☐ Artificial Joint | ☐ Excessive Thirst | ☐ Hives or Rash | ☐ Shingles |
| ☐ Asthma | ☐ Fainting/Syncope | ☐ Hypoglycemia | ☐ Sickle Cell Disease |
| ☐ Blood Disease | ☐ Frequent Cough | ☐ Irregular Heartbeat | ☐ Sinus Trouble |
| ☐ Blood Transfusion | ☐ Frequent Diarrhea | ☑ Kidney Problems | ☐ Stomach Disease |
| ☐ Breathing Problem | ☐ Frequent Headaches | ☐ Leukemia | ☐ Stroke |
| ☐ Bruise Easily | ☐ Genital Herpes | ☐ Liver Disease | ☐ Swelling of Limbs |
| ☐ Cancer | ☐ Glaucoma | ☐ Low Blood Pressure | ☐ Thyroid Disease |
| ☐ Chemotherapy | ☐ Hay Fever | ☐ Lung Disease | ☐ Tonsillitis |
| ☐ Chest Pain | ☑ Heart Attack/Failure | ☐ Mitral valve Prolapse | ☐ Tuberculosis |
| ☐ Cold Sores/Fever Blisters | ☐ Heart Murmur | ☐ Osteoporosis | ☐ Tumors or Growths |
| ☐ Congenital Heart Disease | ☐ Heart Pacemaker | ☐ Pain in Jaw Joints | ☐ Venereal Diseases |
| ☐ Convulsions | ☐ Heart Trouble/Disease | ☐ Parathyroid Disease | ☐ Jaundice |