ARE YOU TAKING ANY OF THE FOLLOWING: (List dosage if taking any of these)

	DOSAGE TIMES TAKEN		DOSAGE TIMES TAKEN
Alcohol (over 3 drinks a day)		Hormone treatment	
Antibiotics or sulfa drugs		Inhalers	
Anticoagulants (coumadin)		Insulin/pills (diabetes meds)	
Antihistamines		Nitroglycerin	
Appetite suppressants		Pain pills	
Aspirin		Potassium	
Birth control pills		Sleeping pills	
Chemotherapy/Xray trmt.		Smoking (over 4 a day)	
Coffee (over 3 cups a day)		Tranquilizers	
Cortisone (steroids)		Water pills	
Eye drops		OTHER MEDICATIONS:	
Heart medication			
High blood pressure meds.			

HAVE YOU HAD ALLERGIC REACTIONS TO ANY OF THE FOLLOWING: (If applicable put an X in box)

Anesthesia	Other antibiotics	Sulfa drugs
Aspirin	Penicillin	Tetanus
Barbiturates	Shellfish	X-ray dye
Codeine	Sleeping pills	Other:

GENERAL QUESTIONS (Circle yes or no)

Are you in good health?	Yes no
Any changes in your general health in the last year?	Yes no
Has a physical exam been done in the last year?	Yes no
Do you have home health aids or visiting nurses?	Yes no
Are you under the care of a physician for an ongoing condition?	Yes no
Have you lost/gained a large amount of weight in the last year?	Yes no
Are you pregnant?	Yes no
Are you hard of hearing?	Yes no
Do you use a walker?	Yes no
Does someone have a Power of Attorney for your affairs?	Yes no

FAMILY HISTORY:

MEMBER	DECEASED	AGE	CAUSE OF DEATH	IF ALIVE, AGE & GENERAL HEALTH
Mother				
Father				
Sibling				
Sibling				
Sibling				

COMMENTS: _____

_____

_____

PLEASE SIGN: _____ **DRS. INITIALS:**_____