# -Medical History

## Cancer & Blood Disorders Treatment Center

Name: _____ Date: _____
Age: _____ Date of Birth: _____
Sex: ____M ____F
Occupation: _____

**Allergies to Medications, X-Ray dyes, or other substances**: ____No ____Yes
If yes, please list the names of medications & type of reaction:

_____
_____

**Past Medical History & Review of Systems**
Please circle if you have had problems with or are presently complaining of any of the following:

1. High Blood Pressure
2. Diabetes
3. High Cholesterol
4. Arthritis
5. Heart Problems
6. Lung Problems
7. Stomach Problems
8. Liver Problems
9. Skin Problems
10. Bone Problems
11. Urinary Problems
12. Psyche Problems
13. Blood Clotting Problems
14. Anemia

Any other problems, please briefly explain in space below

_____
_____

**Past Surgical History & Recent Hospitalizations**
Please list all surgical procedures

_____
_____
_____

**Medications**

| Medication Name | Dosage | Prescription, Over the counter, etc. |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |