-Medical History

Cancer & Blood Disorders Treatment and Infusion 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, Family History & Recent Hospitalizations
Please list all surgical procedures

_____
_____
_____

Medications

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