MEDICAL UPDATE **Patient Name_____ Date _____**

Please tell us if you have had any of the following by checking the appropriate boxes below.

Your Physician's Name _____

CURRENT MEDICATIONS

(If you have a list already, please attach)

☐ Bacterial Endocarditis	☐ Congestive Heart Failure
☐ Heart Murmur	☐ Hemophilia
☐ Irregular Heart Beat	☐ Blood Disease
☐ Liver Problems	☐ Hepatitis-type_____
☐ Ulcer/Colitis	☐ High Blood Pressure
☐ Rheumatic Heart Disease	☐ Angina/Chest Pain
☐ Heart Attack o Year_____	☐ Artificial Heart Valves o Year_____
☐ Osteoporosis	☐ Anemia/Blood Problems
☐ Respiratory Disease	☐ Shortness of Breath
☐ Tuberculosis	☐ Eye Disorders/Glaucoma
☐ Neurological Problems	☐ Epilepsy/Seizures
☐ Drug Addiction	☐ Malignancies
☐ Immunosuppressive Disorders/ARC	☐ Diabetes
☐ Any Artificial Replacements o Type_____ Year_____	☐ Cancers, Tumors, etc. o Type_____Year_____
☐ Kidney Problem	☐ Dialysis
☐ Stroke o Year_____	☐ Thyroid Problems
☐ Low Blood Pressure	☐ Rheumatic Heart Fever
☐ Congenital Heart Lesion	☐ Mitral Valve Prolapse
☐ Heart Pacemaker o Year_____	☐ Heart Surgery
☐ Excessive Bleeding	☐ Asthma
☐ Hay Fever	☐ Sinus Problems
☐ HIV/AIDS	☐ Rheumatism/Arthritis
☐ Alcoholism	☐ Fever Blisters
☐ Sexually Transmitted Diseases	☐ Parkinson's

Name of Drug _____
Strength/Freq _____ Reason _____

Name of Drug _____
Strength/Freq _____ Reason _____

Name of Drug _____
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Name of Drug _____
Strength/Freq _____ Reason _____

Name of Drug _____
Strength/Freq _____ Reason _____

Other conditions not listed:

Any allergies to medications? ◯Yes ◯ No **Surgeries** :

If yes, please list:

_____ _____

Signature of Patient/Guardian I understand that typing my name constitutes a legal signature when submitting this form. Today's Date