

**AB CLIENT
MEDICAL HISTORY**

PATIENT NAME _____ TODAY'S DATE _____

CHART NUMBER _____ DATE OF BIRTH _____

ALLERGIES _____

The information in this questionnaire, like the rest of your medical record, is confidential. It will not be released without written authorization

Is there a history of skin reaction or other untoward reaction or sickness following injection or other administration of:

What drug or food

- | | | | | |
|---|------------------------------|-----------------------------|-------------------------------------|-------|
| Penicillin or other antibiotics | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | _____ |
| Morphine, Codeine, Demerol or other narcotics | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | _____ |
| Novocaine or other anesthetics | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | _____ |
| Aspirin or other pain remedies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | _____ |
| Iodine or Betadine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | _____ |
| Are you allergic to latex (condoms/gloves)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |

Within the past six months has patient taken any of the following drugs?

- | | | | | |
|--|------------------------------|-----------------------------|-------------------------------------|-------|
| Cortisone | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | |
| ACTH | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | |
| Anticoagulants | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | |
| Tranquilizers | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | |
| Anti-Hypertensives (High blood pressure medications) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | |
| Aspirin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | |
| Smoking | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Street Drugs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | _____ |
| Diet Pills | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | _____ |
| Herbal Medicines | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | _____ |

Have you ever received treatment for:

- | | | | |
|------------------------|------------------------------|-----------------------------|-------------------------------------|
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Heart Disease/Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |

List all medications or drugs taken in the last 48 hours _____

If you are taking any drugs, inform the counselor so that there will not be a conflict with drugs we use. This information will be strictly confidential, but if not given could cause serious complications, including death.

SIGNATURE OF PATIENT	DATE
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STAFF SIGNATURE
