14. Please list <u>ALL</u> other medications you currently use. Please be sure to <u>include prescription drugs</u>, <u>vitamins</u> and any <u>over the counter products</u>.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

15. <u>Are you taking any ASPIRIN products</u>? YES _____ NO _____

Do you <u>currently have</u> or (<u>have you ever had</u>) any of the following problems: If yes, please explain:

Diabetes..... ☐ Yes ☐ No _____
Thyroid..... ☐ Yes ☐ No _____
Unexpected weight loss or gain..... ☐ Yes ☐ No _____
Heart Disease..... ☐ Yes ☐ No _____
High Blood Pressure..... ☐ Yes ☐ No _____
Pace Maker, Bypass Surgery..... ☐ Yes ☐ No _____
Congestive Heart Failure..... ☐ Yes ☐ No
Heart Attack..... ☐ Yes ☐ No _____
Stroke..... ☐ Yes ☐ No _____
Lung Disease..... ☐ Yes ☐ No _____
Asthma, Emphysema..... ☐ Yes ☐ No _____
Tuberculosis..... ☐ Yes ☐ No _____
Shortness of Breath..... ☐ Yes ☐ No _____
Stomach Problems..... ☐ Yes ☐ No _____
Ulcers..... ☐ Yes ☐ No _____
Abdominal Pain..... ☐ Yes ☐ No _____
Urinary Problems..... ☐ Yes ☐ No _____
Pain or Discomfort..... ☐ Yes ☐ No _____
Kidney Stones..... ☐ Yes ☐ No _____
Blood In Urine..... ☐ Yes ☐ No _____
Skin Problems..... ☐ Yes ☐ No _____
Changes in Skin Color..... ☐ Yes ☐ No _____
Bleeding trouble..... ☐ Yes ☐ No _____
Blood transfusion..... ☐ Yes ☐ No _____
Hearing Loss..... ☐ Yes ☐ No _____
Sinus Problems..... ☐ Yes ☐ No _____
Muscle Weakness..... ☐ Yes ☐ No _____
Arthritis..... ☐ Yes ☐ No _____
Psychiatric Problems..... ☐ Yes ☐ No _____
Neurological Problems..... ☐ Yes ☐ No _____
Paralysis..... ☐ Yes ☐ No _____
Numbness or Tingling..... ☐ Yes ☐ No _____
Headaches..... ☐ Yes ☐ No _____

*****Please list any other medical condition or disorder not noted above:** _____

_____

Patient's Signature _____ **Date** _____

Physician's Signature _____ **Date** _____