THE WAY TRANSPORTATION SHOULD BE

BeeTRANS

BEE COMFORTABLE TO AND FROM AND ON TIME EVERY TIME.

MEDICAL HISTORY

FIRST NAME ______ LAST NAME ______ AGE ______

PRIMARY PHYSICIAN ______ LOCATION ______

HOW DO YOU RATE YOUR CURRENT HEALTH CONDITION? (CHECK ONE BOX)

☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

RECENT HOSPITAL STAY? ☐ YES ☐ NO IF YES WHY? ______

DATE OF HOSPITAL STAY (EX.02/20/2010) ______

PLEASE MARK ALL THAT APPLY TO YOU BELOW.

1. DO YOU HAVE ANY ALLERGY TO ANY OF THE FOLLOWING:
2. ☐ Aspirin, ibuprofen, acetaminophen, codeine
   ☐ Penicillin
   ☐ Erythromycin
   ☐ Tetracycline
   ☐ Local anesthetic
   ☐ Fluoride
   ☐ Metals (nickel, gold, silver, ______
   ☐ Latex
   ☐ Nuts
   ☐ Fruit ______
   ☐ Other ______.
3. Heart problems, or cardiac stent within the last six months ______
4. History of ineffective endocarditis ______
5. Artificial heart valve, repaired heart defect (PFO) ______
6. Pacemaker or implantable defibrillator ______
7. Orthopedic implant (joint replacement) ______
8. Rheumatic or scarlet fever ______
9. High or low blood pressure ______
10. A stroke (taking blood thinners) ______
11. Anemia or other blood disorder ______
12. Prolonged bleeding due to a sight cut (INR>3.5) ______
13. Pneumonia, emphysema, shortness of breath, sarcoidosis ______
14. Tuberculosis, measles, chicken pox ______
15. Asthma or bronchitis ______
16. Breathing or sleeping problems (i.e. sleep apnea, snoring, sinus) ______
17. Kidney disease ☐
18. Liver disease ☐
19. Jaundice ☐
20. Thyroid, parathyroid disease, or calcium deficiency ______
21. Hormone deficiency ☐
22. High cholesterol or taking statin drugs ______
23. Diabetes ☐
24. Stomach or ulcer ______
25. Digestive or eating disorder ______
26. Osteoporosis/osteopenia ______
27. Arthritis ☐
28. Autoimmune disease ☐ Yes ☐ No
29. Glaucoma ☐ Yes ☐ No

30. Head or neck injuries
31. Epilepsy, convulsions
32. Neurological disorders (ADD/ADHD, prion disease)
33. Viral infections and cold sores
34. Open wounds
35. Hives/skin rash/hay fever
36. STI/STD/HPV
37. Hepatitis/type
38. HIV/AIDS
39. Tumors ☐ Yes ☐ No
40. Radiation therapy ☐ Yes ☐ No
41. Chemotherapy ☐ Yes ☐ No
42. Emotional difficulties ☐ Yes ☐ No
43. Psychiatric treatment ☐ Yes ☐ No
44. Depression ☐ Yes ☐ No
45. Alcohol/recreational drug use

ARE YOU CURRENTLY BEING TREATED TO ANY OF THE FOLLOWING:

46. Any unlisted illness
47. A change in your health in the last 24hrs
48. Taking medication for weight loss ☐ Yes ☐ No
49. Exhaustion and fatigue ☐ Yes ☐ No
50. Experience frequent headaches or migraines ☐ Yes ☐ No
51. Pregnant ☐ Yes ☐ No
52. Experiencing dizziness ☐ Yes ☐ No
53. Vertigo ☐ Yes ☐ No
54. Hemorrhoids or prostate ☐ Yes ☐ No

Are there any special request that are needed please note below?

Signature here Date