



Dr. H. Kevin Jones
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Name: _____ Age: _____ Male Female

Have you ever had any of the following diseases:

- | | | |
|--|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Emotional Disorders | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Stomach Disorders |
| <input type="checkbox"/> Glandular Disorders | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Other | | |

Allergies:

List all drugs you are allergic to and the type of reaction:

Medications:

List all medication and doses currently taking.

Please include any "over the counter" drugs such as aspirin or nasal sprays:

Surgery/Hospitalizations:

List all with appropriate dates please:

Surgery/Hospitalizations	Date	Comments
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you: Smoke _____ Drink Alcohol _____

List any recent injuries & date injured: _____
