William S. Bundrick, M.D.
Don Burt, M.D.

PLEASE COMPLETE THIS FORM FOR BETTER UNDERSTANDING OF YOUR HEALTH HISTORY

DATE _____

Patient's Name _____
Last First Middle

Are you allergic to any type of medicine? ..... YES [] NO []

Any history of peptic ulcer disease? ..... YES [] NO []

Is there a history of free bleeding or excessive bleeding? ..... YES [] NO []

Any known illnesses of:

Brain or spinal cord	YES []	NO []	Diabetes	YES []	NO []
Blood disorder or disease.....	YES []	NO []	Circulation problems.....	YES []	NO []
Heart disease.....	YES []	NO []	Nervous trouble	YES []	NO []
Kidney disease	YES []	NO []	Stomach, intestinal or bowel disorder.....	YES []	NO []
Lung disease	YES []	NO []	Bladder disease.....	YES []	NO []
High blood pressure	YES []	NO []	Sleep Apnea.....	YES []	NO []
Smoker	YES []	NO []	How much?	YES []	NO []

Diagnosis if you know it: _____

Any family history of the above? ..... YES [] NO []

Have you had any type of surgical procedures? ..... YES [] NO []
Please list: _____

Are you presently taking any medication? ..... YES [] NO []
Please list: _____

Are you under medical treatment for any other illnesses? ..... YES [] NO []

Treating physician: _____

Have you taken a cortisone drug for more than a few days? ..... YES [] NO []
For what? _____

Are you pregnant? ..... YES [] NO []
If yes, please give your due date _____

_____
Patient's Signature

**The above information is true and accurate to the best of my knowledge.