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 HEALTH HISTORY **건강기록**

Physician’s name **주치의사**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last visit **최근방문한 날짜**\_\_\_\_\_\_\_\_\_\_\_
Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. YES NO
Have you ever taken any of the group of the drugs collectively referred to as “fen-phen?” These include combinations of Ionimin, Adipex, Fastin (brand name of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). YES NO

*Highlight “yes” or “no” to indicate if you have had any of the following:* **앓고 계신 병명이나, 수술받으셨던 기록이 있으시면 체크 및 적어주세요.**

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| --- | --- | --- |
| AIDS/HIV YES NOAnemia YES NOArthritis, Rheumatism YES NOArtificial Heart Valves YES NOArtificial Joints YES NOAsthma YES NOBack Problems YES NOBleeding abnormally, with YES NOextractions or surgeryBlood Disease YES NOCancer YES NOChemical Dependency YES NOChemotherapy YES NOCholesterol YES NOCirculatory Problems YES NOCongenital Heart Lesions YES NOCortisone Treatments YES NOCough, persistent or bloody YES NODiabetes YES NOEmphysema YES NO | Epilepsy YES NOFainting or dizziness YES NOGlaucoma YES NOHeadaches YES NOHeart Murmur YES NOHeart problems YES NOHepatitis Type \_\_\_\_\_ YES NOHerpes YES NOHigh Blood Pressure YES NOJaundice YES NOJaw Pain YES NOKidney Disease YES NOLiver Disease YES NOLow Blood Pressure YES NOMitral Valve Prolapse YES NONervous Problems YES NOPacemaker YES NOPsychiatric Care YES NORadiation Treatment YES NO | Respiratory Disease YES NORheumatic Fever YES NOScarlet Fever YES NOShortness of Breath YES NOSinus Trouble YES NOSkin Rash YES NOSpecial Diet YES NOStroke YES NOSwollen Feet or Ankles YES NOThyroid Problems YES NOTonsillitis YES NOTuberculosis YES NOTumor of growth on head or YES NO neckUlcer YES NOVenereal Disease YES NOWeight Loss, unexplained YES NODo you wear contact lenses? YES NO |

**Women: (임신여부)**Are you pregnant?\_\_\_\_\_ Due date **출산날짜**\_\_\_\_\_\_\_\_ Are you nursing? YES NO Taking birth control pills?**피임약을 복용하십니까?** YES NO

ALLERGIES **항생제 알러지 체크해주세요.**

*Please highlight any allergies*

|  |  |
| --- | --- |
| Aspirin Barbiturates (Sleeping pills)CodeineIodine | LatexLocal AnestheticPenicillin Sulfa |

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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MEDICATIONS **복용하시는 약종류를 적어주세요**

List any medications you are currently taking and the correlating diagnosis:
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Pharmacy’s name (**약국이름**)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone **약국** **전화번호** (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_