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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 NO Anemia YES NO Arthritis, Rheumatism YES NO Artificial Heart Valves YES NO Artificial Joints YES NO Asthma YES NO Back Problems YES NO Bleeding abnormally, with YES NO extractions or surgery Blood Disease YES NO Cancer YES NO Chemical Dependency YES NO Chemotherapy YES NO  Cholesterol YES NO Circulatory Problems YES NO Congenital Heart Lesions YES NO Cortisone Treatments YES NO  Cough, persistent or bloody YES NO Diabetes YES NO Emphysema YES NO | Epilepsy YES NO Fainting or dizziness YES NO Glaucoma YES NO  Headaches YES NO  Heart Murmur YES NO  Heart problems YES NO  Hepatitis Type \_\_\_\_\_ YES NO  Herpes YES NO  High Blood Pressure YES NO  Jaundice YES NO  Jaw Pain YES NO  Kidney Disease YES NO Liver Disease YES NO  Low Blood Pressure YES NO Mitral Valve Prolapse YES NO  Nervous Problems YES NO  Pacemaker YES NO Psychiatric Care YES NO  Radiation Treatment YES NO | Respiratory Disease YES NO  Rheumatic Fever YES NO Scarlet Fever YES NO Shortness of Breath YES NO  Sinus Trouble YES NO  Skin Rash YES NO  Special Diet YES NO  Stroke YES NO  Swollen Feet or Ankles YES NO  Thyroid Problems YES NO  Tonsillitis YES NO  Tuberculosis YES NO  Tumor of growth on head or YES NO  neck  Ulcer YES NO  Venereal Disease YES NO  Weight Loss, unexplained YES NO  Do 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)  Codeine  Iodine | Latex  Local Anesthetic  Penicillin  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** (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_