

MEDICAL HISTORY

Patient Name _____ Nickname _____

Date of Birth _____

Name of Medical Physician _____

Date of last physical examination _____ Purpose _____

What is your estimate of your general health?

Poor _____ Fair _____ Good _____

HAVE YOU EVER HAD THE FOLLOWING:

	YES	NO		YES	NO
1. hospitalization for illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	13. congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>
date _____ reason _____			14. atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>
date _____ reason _____			15. angina pectoris or arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>
date _____ reason _____			16. do you use nitroglycerin?	<input type="checkbox"/>	<input type="checkbox"/>
date _____ reason _____			If yes, where do you carry it? _____		
2. allergic reaction to			17. any organ transplant	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin <input type="checkbox"/> ibuprofen <input type="checkbox"/> acetaminophen <input type="checkbox"/> advil			18. high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			19. low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			20. stroke.....date _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			21. any joint replacement.....date _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> any other antibiotic			If so what joint? _____		
<input type="checkbox"/> sulfa			22. sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> iodine			23. hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> barbiturates <input type="checkbox"/> sedatives <input type="checkbox"/> sleeping pills			24. anemia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> codeine			25. leukemia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			26. any other blood disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> nitrous oxide			27. prolonged bleeding from slight cut or from surgical procedure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			28. do you bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (gold, nickel, stainless steel)			29. have you ever had a blood transfusion ...	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			date _____ reason _____		
<input type="checkbox"/> any other medications			30. emphysema	<input type="checkbox"/>	<input type="checkbox"/>
3. heart failure (congestive)	<input type="checkbox"/>	<input type="checkbox"/>	31. tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
4. heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	32. do you have a persistent cough	<input type="checkbox"/>	<input type="checkbox"/>
5. rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	33. cough up blood	<input type="checkbox"/>	<input type="checkbox"/>
6. mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	34. diabetes.....type 1.....type 2	<input type="checkbox"/>	<input type="checkbox"/>
7. heart attack	<input type="checkbox"/>	<input type="checkbox"/>	35. hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
8. open heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	36. arthritis	<input type="checkbox"/>	<input type="checkbox"/>
9. scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	37. fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
10. pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	38. Bell's palsy	<input type="checkbox"/>	<input type="checkbox"/>
11. stent.....	<input type="checkbox"/>	<input type="checkbox"/>	39. shingles	<input type="checkbox"/>	<input type="checkbox"/>
12. artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	40. multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
			41. lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO		YES	NO
42. scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	72. Viral infections or cold sores	<input type="checkbox"/>	<input type="checkbox"/>
43. osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	73. Any lumps or swelling in the mouth	<input type="checkbox"/>	<input type="checkbox"/>
44. myasthenia gravis	<input type="checkbox"/>	<input type="checkbox"/>	74. head or neck injuries	<input type="checkbox"/>	<input type="checkbox"/>
45. cancer.... type_____date_____	<input type="checkbox"/>	<input type="checkbox"/>	75. frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
46. skin cancer....type_____date_____	<input type="checkbox"/>	<input type="checkbox"/>	76. exhausted or fatigued	<input type="checkbox"/>	<input type="checkbox"/>
47. tumors, abnormal growths	<input type="checkbox"/>	<input type="checkbox"/>	77. alcohol or drug dependency	<input type="checkbox"/>	<input type="checkbox"/>
48. chemotherapy treatments.why_____date_____	<input type="checkbox"/>	<input type="checkbox"/>	78. anorexia or bulimia	<input type="checkbox"/>	<input type="checkbox"/>
49. radiation treatments...why_____date_____	<input type="checkbox"/>	<input type="checkbox"/>	79. ADD or ADHD	<input type="checkbox"/>	<input type="checkbox"/>
50. fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	80. smoker or tobacco chewer	<input type="checkbox"/>	<input type="checkbox"/>
51. epilepsy, seizures	<input type="checkbox"/>	<input type="checkbox"/>	81. FEMALE- taking birth control pill	<input type="checkbox"/>	<input type="checkbox"/>
52. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	82. FEMALE- trying to get pregnant	<input type="checkbox"/>	<input type="checkbox"/>
53. any other eye diseases	<input type="checkbox"/>	<input type="checkbox"/>	83. FEMALE- are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>
54. wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	84. MALE- prostate disease	<input type="checkbox"/>	<input type="checkbox"/>
55. deafness, wear hearing aids	<input type="checkbox"/>	<input type="checkbox"/>	85. emotional problems	<input type="checkbox"/>	<input type="checkbox"/>
56. asthma	<input type="checkbox"/>	<input type="checkbox"/>	86. psychiatric treatments	<input type="checkbox"/>	<input type="checkbox"/>
57. hay fever	<input type="checkbox"/>	<input type="checkbox"/>	87. antidepressant medications	<input type="checkbox"/>	<input type="checkbox"/>
58. skin rash, hives	<input type="checkbox"/>	<input type="checkbox"/>	88. apprehensive person	<input type="checkbox"/>	<input type="checkbox"/>
59. sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	89. easily upset or irritated	<input type="checkbox"/>	<input type="checkbox"/>
60. kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
61. kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	89. presently taking or have taken:		
62. renal dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Fen-Phen <input type="checkbox"/> Redux		
63. liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pondinum [diet drugs]	<input type="checkbox"/>	<input type="checkbox"/>
64. jaundice	<input type="checkbox"/>	<input type="checkbox"/>	90. taking		
65. hepatitis.....type_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ma Huang <input type="checkbox"/> Kava <input type="checkbox"/> St. John's Wort		
66. thyroid or parathyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ephedra <input type="checkbox"/> Ginkgo Biloba	<input type="checkbox"/>	<input type="checkbox"/>
67. high cholestrol	<input type="checkbox"/>	<input type="checkbox"/>	91. any other herbal supplements	<input type="checkbox"/>	<input type="checkbox"/>
68. stomach or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	If so, what _____		
69. any other gastrointestinal or digestive disorders ..	<input type="checkbox"/>	<input type="checkbox"/>	92. taking any vitamin supplements	<input type="checkbox"/>	<input type="checkbox"/>
70. HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	If so, what _____		
71. Venereal disease.... type_____	<input type="checkbox"/>	<input type="checkbox"/>	93. taking any steroid medications		
			reason? _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any medical condition or disease not listed above? _____

If so, what? _____

List all medications currently taking and the medical condition they are for.

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient's Signature _____ Date _____

Doctor's Remarks: _____

_____ Doctor's Signature _____