

MEDICAL HISTORY

Patient's Name: _____

Date: _____

	Yes	No	Mo/Yr		Yes	No	Mo/Yr
Sinusitis				Diabetes			
Glaucoma				Epilepsy			
Cancer				Stroke			
Radiation Therapy				Nervous Disorder			
Heart Attack				Venereal Disease			
Angina (Chest Pain)				AIDS			
Chest Surgery				Substance Abuse			
Heart Murmur (MVP)				Emotional Disorder			
Pacemaker				Mental Health Aid			
Arrhythmia (irr pulse)				Prosthetic Joints			
Other Heart Condition				Rheumatic Fever			
High Blood Pressure							
Asthma				Other List Below:			
Emphysema							
Bronchitis							
Tuberculosis							
Ulcers							
Hepatitis							
Kidney Disease							
Dialysis							
Thyroid Disease							

Allergic to any drugs? (please list): _____

Other Allergies: _____

Height: _____ Weight: _____ Age: _____ Date of Birth: _____

Pregnant? _____ If yes, months: _____

Are you taking the following medications?

	Yes	No		Yes	No
Digitalis			Insulin		
Nitroglycerine			Steroids		
Blood Pressure Medication			Antidepressants		
Breathing Machine					
Asprin (daily)					
Blood Thinners					

List Medications and Dosages:

	Yes	No
Are you under the care of a physician?		
Have you been hospitalized in the last 5 years? If yes list below.		
Have you ever had surgery in a hospital or outpatient?		
Have you ever had problems with general anesthesia? If yes list below		
Do you smoke? How many packs per day?		
Do you have any other illnesses?		

Remarks:

I certify that the above medical information is correct. ✓

Signed: _____ Print Name _____

Date: _____