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WE APPRECIATE YOUR COOPERATION IN FILLING OUT THIS FORM

MEDICAL HISTORY

PATIENT'S NAME (Last, First)	DATE OF BIRTH	AGE

PHYSICIAN'S NAME:	ADDRESS:	PHONE NUMBER:

PLEASE CHECK OR CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE HAD OR PRESENTLY HAVE:

- ☐ HEART ATTACK / MI
- ☐ HEART FAILURE
- ☐ ANGINA (CHEST PAIN)
- ☐ HIGH / LOW BLOOD PRESSURE
- ☐ IRREGULAR HEART BEAT
- ☐ PALPITATIONS
- ☐ HEART MURMUR
- ☐ MITRAL VALVE PROLAPSE
- ☐ RHEUMATIC / SCARLET FEVER
- ☐ CONGENITAL HEART LESIONS
- ☐ HEART BYPASS / ANGIOPLASTY
- ☐ HEART VALVE REPLACEMENT
- ☐ HEART PACEMAKER
- ☐ OTHER HEART SURGERY
- ☐ CIRCULATORY PROBLEMS
- ☐ STROKE / CVA
- ☐ ANEURYSM
- ☐ AIDS / ARC / HIV POSITIVE
- ☐ DRUG / ALCOHOL ADDICTION
- ☐ LIVER DISEASE / CIRRHOSIS
- ☐ HEPATITIS A / B / C / D
- ☐ JAUNDICE
- ☐ BRUISE EASILY
- ☐ HEMOPHILIA (BLEEDING PROBLEMS)
- ☐ SICKLE CELL DISEASE / TRAIT
- ☐ BLOOD TRANSFUSION
- ☐ KIDNEY DISEASE / STONES
- ☐ BLADDER / PROSTATE PROBLEMS
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ (Syphillis, Gonnorrhea, Chlamydia, Herpes)
- ☐ SHORT OF BREATH
- ☐ COUGH
- ☐ EMPHYSEMA
- ☐ TUBERCULOSIS (TB)
- ☐ ASTHMA
- ☐ HAY FEVER / ALLERGIES
- ☐ SINUS DISEASE
- ☐ HIVES
- ☐ NERVOUSNESS
- ☐ PSYCHIATRIC TREATMENT
- ☐ EPILEPSY / SEIZURES
- ☐ NEUROLOGICAL DISEASE
- ☐ CRANIAL SURGERY
- ☐ GLAUCOMA
- ☐ ARTHRITIS
- ☐ ARTIFICIAL JOINTS
- ☐ DIABETES
- ☐ THYROID DISEASE
- ☐ STOMACH / INTESTINAL ULCERS
- ☐ COLITIS
- ☐ CANCER / TUMORS
- ☐ DIALYSIS
- ☐ CHEMOTHERAPY
- ☐ RADIATION TREATMENT
- ☐ CORTISONE THERAPY
- ☐ ORGAN TRANSPLANT

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? YES ☐ NO ☐	FOR WHAT CONDITION?

DO YOU TAKE ANY MEDICATIONS REGULARY? (PLEASE LIST)	WHEN WAS YOUR LAST PHYSICAL EXAM (TESTS?)

ARE YOU TAKING ANY OTHER MEDICATIONS CURRENTLY? (PLEASE LIST)

ARE YOU ALLERGIC TO OR HAD A BAD REACTION TO ANY MEDICATION, ANESTHESIA, FOODS, OR OTHER SUBSTANCES? (PLEASE LIST)

HAVE YOU BEEN HOSPITALIZED FOR TREATMENTS OR SURGERY? (PLEASE LIST)

DO YOU SMOKE CIGARETTES, CIGARS, PIPE OR USE CHEWING TOBACCO?	HOW OFTEN?	FOR HOW MANY YEARS?

DO YOU DRINK ALCHOLIC BEVERAGES / HOW OFTEN?	ARE YOU ON A SPECIAL DIET? ☐ YES ☐ NO	DO YOU WEAR CONTACT LENSES? ☐ YES ☐ NO

WOMEN: ARE YOU PREGNANT NOW?	DO YOU ANTICIPATE BECOMING PREGNANT?	ARE YOU PRACTICING BIRTH CONTROL? WHAT TYPE:

DO YOU HAVE ANY OTHER DISEASES, CONDITION, OR PROBLEM, NOT LISTED?

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM THE DOCTOR AT THE NEXT APPOINTMENT WITHOUT FAIL.

Date	Signature of Patient, Parent or Guardian	Witness

MEDICAL HISTORY / PHYSICAL EVALUATION UPDATE

Date	Changes - If None So Indicate	Signature	Witness