Medical History

Date_____

Patient Name:_____Date of Birth_____

Weight _____ Height_____

Patient History

Please Circle any of the following that you have had:

AIDS/HIV
Allergies
Anemia
Angina
Bladder Infections
Blood Clots
Bronchitis
Cancer
Chemical Dependency
Circulatory Problems
Colitis
Diabetes
Emphysema
Epilepsy
Foot/ Leg cramps
Gout
Headaches
Heart Attack
Heart Disease
Heart Murmur
Hernia
Hepatitis or Jaundice
High Blood Pressure
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Neuropathy
Pneumonia
Phlebitis
Rheumatic Fever
Seizures
Shortness of Breath
Sinus Problems
Stroke
Thyroid or Goiter
Tuberculosis(TB)
Ulcers
Varicose Veins
Venereal Disease(STD)
Other:_____
_____
_____
_____

Family History

(Please Circle and state the relationship if your Biological parents, Siblings or children have or have ever had any of the following:)

	Relationship
Tuberculosis	_____
High Blood Pressure	_____
Heart Disease	_____
Kidney Disease	_____
Diabetes	_____
Cancer/Tumor	_____
Anemia	_____
Thyroid	_____
Glaucoma	_____
Other	_____

Allergies

Circle if you have any of the following and write the reaction you have had

	reaction		reaction
Adhesive/Tape	_____	Local Anesthetics	_____
Asprin	_____	Novocaine	_____
Codeine	_____	Penicillin	_____
Demerol	_____	Sulfa	_____
Iodine	_____	Other:	_____
Latex	_____		_____

Food Allergies :

_____
_____

Surgical History

List All Since Birth

	Surgery	Year
1.	_____	
2.	_____	
3.	_____	
4.	_____	
5.	_____	
6.	_____	
7.	_____	
8.	_____	
9.	_____	

Procedure History

Examples: Colonoscopy, Endoscopy, etc)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Additional Info

Do you understand English	Yes	No
Are you an Organ Donor	Yes	No
Do you have any metal flakes in the eyes	Yes	No
Are your Immunizations up to date?	Yes	No
Do you have a Living Will	Yes	No
Do you have a Durable Power of Attorney	Yes	No

Any difficulty with any of the following:
Reading Writing Hearing Vision

Do you smoke	Yes	No
Do you Drink Alcohol	Yes	No
Do you take drugs other than prescription	Yes	No