MEDICAL HEALTH HISTORY

HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH?

Excellent Good Fair Poor

LIST YOUR CURRENT PHYSICIANS(S)

1)_____ Type_____ How Long?_____

2)_____ Type_____ How Long?_____

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Are you aware of any changes your general health in the last year? ☐ YES ☐ NO

Have you been hospitalized for illnesses or surgery during the past two years? ☐ YES ☐ NO

Have you been under the care of a medical doctor during the past two years? ☐ YES ☐ NO

Any history of diabetes in your family? ☐ YES ☐ NO

Are you required to restrict your work activities in any way? ☐ YES ☐ NO

Do you smoke ? ☐ YES ☐ NO

LIST ALL MEDICINES THAT YOU ARE NOW TAKING (include all OTC)

_____

_____

Please list all allergies_____

_____

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT-Circle YES or NO

Heart trouble	☐ NO ☐ YES	Artificial Joint (Knee, Hip)	☐ NO ☐ YES	Cancers or Tumors	☐ NO ☐ YES
Heart Disease or Attack	☐ NO ☐ YES	Kidney/Bladder Trouble	☐ NO ☐ YES	Radiation Treatment	☐ NO ☐ YES
Angina	☐ NO ☐ YES	Thyroid Disease	☐ NO ☐ YES	Chemotheraphy	☐ NO ☐ YES
High Blood Pressure	☐ NO ☐ YES	Emphysema	☐ NO ☐ YES	Arthritis/Rheumatism	☐ NO ☐ YES
Low Blood Pressure	☐ NO ☐ YES	Persistent cough	☐ NO ☐ YES	Glaucoma	☐ NO ☐ YES
Heart Murmur	☐ NO ☐ YES	Tuberculosis	☐ NO ☐ YES	Contact Lenses	☐ NO ☐ YES
Rheumatic Fever	☐ NO ☐ YES	Asthma	☐ NO ☐ YES	Hepatitis	☐ NO ☐ YES
Congenital Heart Lesions	☐ NO ☐ YES	Hay Fever	☐ NO ☐ YES	Liver Disease	☐ NO ☐ YES
Artificial Heart Valve	☐ NO ☐ YES	Sinus Troubles	☐ NO ☐ YES	Jaundice	☐ NO ☐ YES
Scarlet Fever	☐ NO ☐ YES	Allergies or Hives	☐ NO ☐ YES	AIDS	☐ NO ☐ YES
Heart Pacemaker	☐ NO ☐ YES	Diabetes	☐ NO ☐ YES	Blood Transfusion	☐ NO ☐ YES
Heart Surgery	☐ NO ☐ YES	Frequent Thirst	☐ NO ☐ YES	Drug or Alcohol Add	☐ NO ☐ YES
Shortness of Breath	☐ NO ☐ YES	Stroke	☐ NO ☐ YES	Hemophelia	☐ NO ☐ YES
Epilepsy or Seizures	☐ NO ☐ YES	Ankles Swell	☐ NO ☐ YES	Frequent Headaches	☐ NO ☐ YES
Anemia	☐ NO ☐ YES	Sickle Cell Anemia	☐ NO ☐ YES	Fainting Spells	☐ NO ☐ YES
Ulcers	☐ NO ☐ YES	Psychiatric Care	☐ NO ☐ YES	Weight gain/Loss	☐ NO ☐ YES

If Female are you:

Pregnant? ☐ NO ☐ YES Through Menopause? ☐ NO ☐ YES

Taking birth control ☐ NO ☐ YES Taking Hormone Medication ☐ NO ☐ YES

Do you have ay medical condition/diseases not listed above that we should know about?

☐ NO ☐ YES Explain:_____

The best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medicines change. I will inform the doctor on or before my next doctors appt. without fail.

_____ _____

Doctor's Signature Date Patient's Signature Date