Medical Health History

Date: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CHECK ANY THAT APPLY.

Heart Problems ❑
- Chest Pain ❑
- Shortness of breath ❑
- Blood pressure problem ❑
- Heart murmur ❑
- Mitral valve prolapse ❑
- Taking heart medication ❑
- Rheumatic fever ❑
- Pacemaker ❑
- Artificial heart valve ❑
- Heart attack ❑

Blood Problems ❑
- Easy bruising ❑
- Frequent nose bleeds ❑
- Abnormal bleeding ❑
- Blood disease (anemia) ❑

Allergy Problems ❑
- Hay fever ❑
- Sinus problems ❑
- Skin rashes, hives ❑
- Taking allergy medication ❑
- Asthma ❑
- Metal allergy ❑

Intestinal Problems ❑
- Ulcers ❑
- Weight gain or loss ❑
- Special diet ❑
- Constipation ❑

Bone or Joint Problems ❑
- Arthritis ❑
- Back or neck pain ❑
- Joint replacement (e.g., total hip) ❑

Fainting Spells, Seizures or Epilepsy ❑
- Stroke ❑

Hospitalization for
- Surgery ❑
- Illness ❑
- Accident ❑
- Other ❑

Are you allergic or have you reacted adversely to any of the following?
- Dental anesthetics or Epinephrine ❑
- Penicillin ❑
- Sulfa drugs ❑
- Barbiturates, sedatives or sleeping pills ❑
- Aspirin or ibuprofen ❑
- Codeine or other narcotics ❑
- Other ❑

Diabetes ❑
- Urinate more than 6 times a day ❑
- Thirsty or mouth is dry much of the time ❑
- Family history of diabetes ❑

Tuberculosis or other respiratory disease ❑

Cancer/Tumor ❑

Do you drink alcohol? ❑
- If so how much? ❑

Do you smoke or chew tobacco? ❑
- If so how much? ❑

Do you have emphysema? ❑

Hepatitis, Jaundice or Liver trouble ❑

Herpes ❑

HIV-Positive/AIDS ❑

Glaucoma ❑

Do you wear contact lenses? ❑

Kidney disease ❑

Thyroid/Parathyroid disorder ❑

During the past 12 months have you taken any of the following?
- Antibiotics or sulfa drugs ❑
- Anticoagulants (e.g., Coumadin) ❑
- High blood pressure medicine ❑
- Tranquilizers or antidepressants ❑
- Insulin, Orinase or a similar drug ❑
- Aspirin ❑
- Digitalis or drugs for heart trouble ❑
- Nitroglycerin ❑
- Cortisone (steroids) ❑
- Have you ever taken Phen-Fen? ❑
- Other ❑

Women
- Are you taking contraceptives or other hormones? ❑
- Are you pregnant? ❑

Do you have any disease, condition or problem not listed previously? _____

_____

Physician's Name _____ Phone: _____ Address: _____

Other Physician's Name _____ Phone: _____ Address: _____

Reviewed by: _____ Date: _____

Medical Updates

I've read my medical history and confirm that it states past and present conditions

Date	Changes		Patient's Signature	B.P./Pulse	Reviewed By
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____