

# 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 \_\_\_\_\_
- Tranquillizers 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 <input type="checkbox"/>	_____	_____	Dr. _____
_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	None <input type="checkbox"/>	_____	_____	Dr. _____