

# Medical History

Your Name \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Date of last health care exam: \_\_\_\_\_ What was this exam for? \_\_\_\_\_

Have you been hospitalized in the last 5 years? (Please circle one) NO YES

If yes, reason: \_\_\_\_\_

Are you currently receiving care? (Please circle one) NO YES

Please list the names and phone numbers of physicians who are currently providing you care:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## Please check which of the following apply:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Bacterial Endocarditis   | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Any Artificial Replacement   | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Blood Disease            | <input type="checkbox"/> Artificial Knee, Hip, Joint, | <input type="checkbox"/> Kidney Problems       |
| <input type="checkbox"/> Irregular Heart Beat     | <input type="checkbox"/> Sickle Cell Anemia       | <input type="checkbox"/> Pins, Plate                  | <input type="checkbox"/> Dialysis              |
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Anemia / Blood Problems  | <input type="checkbox"/> Rheumatism / Arthritis       | <input type="checkbox"/> Liver Problems        |
| <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Excessive Bleeding       | <input type="checkbox"/> Neurological Problems        | <input type="checkbox"/> Hepatitis             |
| <input type="checkbox"/> Rheumatic Heart Fever    | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Epilepsy / Seizures          | <input type="checkbox"/> Thyroid Problems      |
| <input type="checkbox"/> Rheumatic Heart Disease  | <input type="checkbox"/> Respiratory Disease      | <input type="checkbox"/> Psychiatric Problems         | <input type="checkbox"/> Ulcer / Colitis       |
| <input type="checkbox"/> Artificial Heart Valves  | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Emotional Problems           | <input type="checkbox"/> Venereal Disease      |
| <input type="checkbox"/> Congenital Heart Lesion  | <input type="checkbox"/> Hay Fever                | <input type="checkbox"/> Alcoholism                   | <input type="checkbox"/> Herpes                |
| <input type="checkbox"/> Mitral Valve Prolapse    | <input type="checkbox"/> Sinus Problems           | <input type="checkbox"/> Chemical Dependency          | <input type="checkbox"/> Fever Blisters        |
| <input type="checkbox"/> Heart Attack _____ year  | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Drug Addiction               | <input type="checkbox"/> Pregnant _____ months |
| <input type="checkbox"/> Angina / Chest Pain      | <input type="checkbox"/> Eye Disorders / Glaucoma | <input type="checkbox"/> Malignancies                 | <input type="checkbox"/> Nursing               |
| <input type="checkbox"/> Heart Pacemaker          | <input type="checkbox"/> AIDS                     | <input type="checkbox"/> Cancers, Tumors, Growths     | <input type="checkbox"/> Oral Contraceptives   |
| <input type="checkbox"/> Heart Surgery            | <input type="checkbox"/> Immunosuppressive        | <input type="checkbox"/> Radiation Treatments         | <input type="checkbox"/> Smoke ?/day _____     |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Disorders / ARC          | <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Drink ?/day _____     |

Do you have abnormal blood pressure? (Please circle one) NO YES

If yes, what is it usually: S \_\_\_\_\_/D \_\_\_\_\_

Please list any **ALLERGIES to Drugs, Medications, Anesthetics or other (latex, food, etc...)**:

\_\_\_\_\_

Please list any **other MEDICAL CONDITIONS** not listed above:

\_\_\_\_\_

Please list all **Drugs, Medications, Vitamins or Supplements** (Include the dosage and frequency):

\_\_\_\_\_

\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Health History Update:** To the best of my knowledge, all the preceding answers are current.

Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_

Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_