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:

____Bacterial Endocarditis
____Heart Murmur
____Irregular Heart Beat
____High Blood Pressure
____Low Blood Pressure
____Rheumatic Heart Fever
____Rheumatic Heart Disease
____Artificial Heart Valves
____Congenital Heart Lesion
____Mitral Valve Prolapse
____Heart Attack _____ year
____Angina / Chest Pain
____Heart Pacemaker
____Heart Surgery
____Congestive Heart Failure

____Hemophilia
____Blood Disease
____Sickle Cell Anemia
____Anemia / Blood Problems
____Excessive Bleeding
____Asthma
____Respiratory Disease
____Shortness of Breath
____Hay Fever
____Sinus Problems
____Tuberculosis
____Eye Disorders / Glaucoma
____AIDS
____Immunosuppressive Disorders / ARC

____Any Artificial Replacement Artificial Knee, Hip, Joint, Pins, Plate
____Rheumatism / Arthritis
____Neurological Problems
____Epilepsy / Seizures
____Psychiatric Problems
____Emotional Problems
____Alcoholism
____Chemical Dependency
____Drug Addiction
____Malignancies
____Cancers, Tumors, Growths
____Radiation Treatments
____Stroke

____Diabetes
____Kidney Problems
____Dialysis
____Liver Problems
____Hepatitis
____Thyroid Problems
____Ulcer / Colitis
____Venereal Disease
____Herpes
____Fever Blisters
____Pregnant ___ months
____Nursing
____Oral Contraceptives
____Smoke ?/day ____
____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 _____