

Medical History Form

Patient's Last Name _____ Middle Initial _____ First Name _____

Are you currently under the care of a physician? No Yes

For what reason: _____

When was your last physical exam? _____

Physician's Name _____

Address _____ Phone _____ Last time seen _____

Have you ever been hospitalized? No Yes

If yes, please explain _____

Are you taking any prescription medication? No Yes

If yes, please explain _____

Are you taking any over the counter medication? No Yes

If yes, please explain _____

Do you have any allergies? No Yes

If yes, please explain _____

Are you allergic to any medications or substances? No Yes

If yes, please explain _____

Do you have any problems with antibiotics or anesthetics? No Yes

If yes, please explain _____

Do you take appetite suppressants? No Yes Name of product: _____

Have you ever had any of the following diseases or medical conditions?

- | | | | |
|--|-------------------------|--|-------------------------|
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Heart Attack/Stroke | <input type="checkbox"/> No <input type="checkbox"/> Yes | Epilepsy |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Cancer/Chemotherapy | <input type="checkbox"/> No <input type="checkbox"/> Yes | Seizures |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Heart Murmur | <input type="checkbox"/> No <input type="checkbox"/> Yes | Fainting |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Rheumatic Fever | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | HIV/AIDS | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tuberculosis |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis A | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hemophilia |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis B | <input type="checkbox"/> No <input type="checkbox"/> Yes | Blood Transfusion |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis C | <input type="checkbox"/> No <input type="checkbox"/> Yes | High Blood Pressure |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis D | <input type="checkbox"/> No <input type="checkbox"/> Yes | Low Blood Pressure |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Anemia | <input type="checkbox"/> No <input type="checkbox"/> Yes | Radiation Treatment |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Mitral Valve Prolapse | <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney Problems |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Artificial Bones/Joints | <input type="checkbox"/> No <input type="checkbox"/> Yes | Artificial Valves |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Sinus Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes | Severe Headaches |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Asthma | <input type="checkbox"/> No <input type="checkbox"/> Yes | Frequent Headaches |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Difficulty Breathing | <input type="checkbox"/> No <input type="checkbox"/> Yes | Emphysema |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Venereal Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Shingles |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Herpes Type I | <input type="checkbox"/> No <input type="checkbox"/> Yes | Herpes Type II |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Heart Surgery | <input type="checkbox"/> No <input type="checkbox"/> Yes | Pace Maker |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Psychiatric Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes | Glaucoma |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Do You Smoke? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Do You Consume Alcohol? |

Are You Allergic To Any of The Following?

- | | | | |
|--|--------------------------|--|-----------------------|
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Penicillin | <input type="checkbox"/> No <input type="checkbox"/> Yes | Codeine |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Aspirin | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tetracycline |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Erythromycin | <input type="checkbox"/> No <input type="checkbox"/> Yes | Germicides/Pesticides |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Latex/or Rubber Products | <input type="checkbox"/> No <input type="checkbox"/> Yes | Other _____ |

For Women Only:

- | | | | |
|--|----------------------------|--|-------------------------------|
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Taking Birth Control Pills | <input type="checkbox"/> No <input type="checkbox"/> Yes | Pregnant/No. of Months: _____ |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Nursing? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hormone Therapy |

Signature _____ Date _____