

Medical History

Name _____ **Date:** _____

Have you been under the care of, or examined by a physician recently?

Yes No

Are you currently or within the last year taking any medicines or drugs?

Yes No

If yes, please list on next page.

Are you currently taking any vitamins or herbal supplements?

Yes No

If yes, please list on next page.

Do you have any allergies?

Yes No

If yes, please list on next page.

Have you ever been warned against taking any specific types of medication?

Yes No

Have you or a blood relative of yours ever had an unpleasant experience with drug or anesthetic?

Yes No

Has your energy level, weight or appetite changed dramatically recently?

Yes No

Do you follow a special diet?

Yes No

Are you pregnant?

Yes No

Do you bleed more than 10 minutes from a cut?

Yes No

Do you have any restricted movement of your neck?

Yes No

Have you ever fainted?

Yes No

Do you ever get fluttering or pounding feeling in your chest?

Yes No

Do you have chest pain on exertion?

Yes No

Do your ankles, feet or hands swell?

Yes No

Do you get short of breath after climbing two flights of stairs?

Yes No

Do you have difficulty breathing through your nose?

Yes No

Are you thirsty much of the time or do you urinate more than 6 times daily?

Yes No

Do you find yourself hot or cold when others around are comfortable?

Yes No

Have you ever had an illness that resulted in a long absence from school or work?

Yes No

Have you ever been in the hospital overnight?

Yes No

Have you ever had an operation?

Yes No

Do you currently or have you ever smoked?

Yes No

If yes, how many:

Do you drink alcohol?

Yes No

If yes, how much:

Do any diseases seem to run in your family?

Yes No

If yes, please list on next page.

Do you wear contact lenses?

Yes No

Have you ever had any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/ Seizures | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Malignant Hyperthermia |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis/ Gout | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> AIDS/ HIV | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Rhythm Disorder | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis B / C | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cortisone/ Steroid | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Lung Disease | |

Current Medications, Allergies and Notes

Medications:

Allergies:

Notes/Misc:

Medical History Update

	Date:	Date:	Date:	Date:
Have there been any changes in your medical history?				
Have you had any serious illnesses?				
Are you taking any new medication?				
Are you under the care of a physician?				
Women: Are you pregnant?				

I understand the preceding questions and I have answered them truthfully and completely.

Signature _____