

# MEDICAL HISTORY FORM

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

General Health:       good       fair       poor

1. Please list all food and drug allergies.

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2. Please list all medications you now take (including over the counter meds, i.e. aspirin).

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3. Please list all operations you have had.

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4. Please list your medical problems.

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5. Please list your present height and weight. \_\_\_\_\_

CHECK YES IF YOU HAVE EVER HAD:

COMMENTS

- |                         |                          |       |
|-------------------------|--------------------------|-------|
| 1. A heart attack       | <input type="checkbox"/> | _____ |
| 2. Heart disease        | <input type="checkbox"/> | _____ |
| 3. A heart murmur       | <input type="checkbox"/> | _____ |
| 4. Chest pain or angina | <input type="checkbox"/> | _____ |
| 5. High blood pressure  | <input type="checkbox"/> | _____ |

- 6. A stroke/mini stroke/TIA  \_\_\_\_\_
- 7. Fainting episodes  \_\_\_\_\_
- 8. Epilepsy/seizures/falling out  \_\_\_\_\_
- 9. Shortness of breath when resting  \_\_\_\_\_
- 10. Shortness of breath when climbing stairs  
or walking  \_\_\_\_\_

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CHECK YES IF YOU HAVE EVER HAD:	COMMENTS
11. Shortness of breath at night	<input type="checkbox"/> _____
12. Asthma/emphysema/COPD-chronic obstructive pulmonary disease	<input type="checkbox"/> _____
13. Chronic bronchitis	<input type="checkbox"/> _____
14. Tuberculosis	<input type="checkbox"/> _____
15. An abnormal chest x-ray (specify)	<input type="checkbox"/> _____
16. Diabetes/trouble with your blood sugar	<input type="checkbox"/> _____
17. Kidney problems	<input type="checkbox"/> _____
18. Arthritis/joint problems	<input type="checkbox"/> _____
19. Heartburn/ulcer/hiatal hernia	<input type="checkbox"/> _____
20. Cancer (specify)	<input type="checkbox"/> _____
21. Chemotherapy (specify)	<input type="checkbox"/> _____
22. Liver problems/jaundice/hepatitis	<input type="checkbox"/> _____
23. Anemia/iron poor blood/low blood count	<input type="checkbox"/> _____
24. Bleeding tendencies	<input type="checkbox"/> _____
25. Thyroid problems	<input type="checkbox"/> _____
26. A significant weight loss without trying to diet	<input type="checkbox"/> _____
27. Mental/emotional/nervous disorders	<input type="checkbox"/> _____
28. Eye problems	<input type="checkbox"/> _____
29. Frequent headaches/migraines	<input type="checkbox"/> _____
30. A problem with anesthesia	<input type="checkbox"/> _____

CHECK YES OR NO TO INDICATE  
WHETHER YOU CURRENTLY:    YES    NO    COMMENTS

32. Smoke cigarettes (specify number of packs per day)	<input type="checkbox"/>	<input type="checkbox"/>	_____
33. Drink alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
34. Could be pregnant ?	<input type="checkbox"/>	<input type="checkbox"/>	_____
35. Have a cold or cough?	<input type="checkbox"/>	<input type="checkbox"/>	_____

36. Have bridgework, dentures, chipped  
or loose teeth, caps, braces   \_\_\_\_\_
37. Have any physical disabilities   \_\_\_\_\_

**I certify that the above information is true and correct to the best of my knowledge.**

\_\_\_\_\_  
**Patient/guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Reviewed by**

\_\_\_\_\_  
**Date**