MEDICAL HISTORY

Patient____Date____________________________________

Name of Physician____Phone___________________________________

Clinic or Facility Name____

Whom may we notify in case of emergency?____

Relationship to you____Phone___________________________________

WHEN WAS YOUR LAST PHYSICAL EXAMINATION?__________________________

Circle a definite answer for each question.

Yes No Any change in your health in the last two years?____

Yes No Are you currently under the care of a physician? If yes, describe your treatment._________________________

____

Yes No Have you had any medical treatment or physician visit of any kind in the last two years? If yes, describe

____

Yes No Have you ever had any surgical operation of any kind? If yes, describe____________________________________

____

Yes No Were you transfused at that time?________________________________

Yes No Have you been advised by a physician of the need for any type of surgery or treatment? For what?

____

DO YOU HAVE, HAVE YOU HAD, OR BEEN TREATED FOR ANY OF THE FOLLOWING?

Yes No Arthritis

Yes No Rheumatic Fever

Yes No Heart Problems, Family History

Yes No High Blood Pressure

Yes No Low Blood Pressure

Yes No Anemia, Sickle Cell Disease

Yes No Epilepsy Seizures

Yes No Fainting Spells

Yes No Diabetes, Family History

Yes No Hepatitis

Yes No Ulcers

Yes No Kidney Disorder

Yes No Tuberculosis (TB)

Yes No Enzyme Deficiency

Yes No HIV

Yes No Hydrocephalus

Yes No Anorexia, Bulimia

Yes No Chemical Dependency

Yes No Panic Attack, Phobia, Extreme Nervousness

Yes No Thyroid Condition

Yes No Venereal Disease, Herpes II

Yes No AIDS

Yes No Pacemaker

Yes No Hip or Joint Replacement

Yes No Allergy

Yes No Cancer

Yes No Radiation or Chemical Therapy

Yes No Ear Infections

Yes No Chronic Sinus

Yes No Respiratory Problems, Asthma

Yes No Hemophilia, Bleeding or Blood Disorder

Yes No Aids Related Complex (ARC)

Yes No Hypothermia

Yes No Heart Murmur, Mitral Valve Prolapse

Yes No Metal Sensitivity

Yes No Latex Sensitivity

Yes No Chronic Diarrhea

Yes Nka Have you ever had an allergic reaction or been told not to take any medication? If yes, describe

____

Yes No Are you currently taking any prescription drugs of any kind (example, birth control, hormone, diet)? If yes, what?____

Yes No Are you currently taking any nonprescription drugs of any kind (example, aspirin, cough syrup, nasal spray, recreational drug use, sugar, caffeine)? If yes, what?____

Yes No Are you pregnant? Anticipated delivery date_____________________

Yes No Do you use any tobacco product? Daily intake_____________________

Yes No Do you wear contact lenses?_____________________________________

Blood Pressure: S_____/D_____

I certify the above to be true and correct to the best of my knowledge.

SIGNATURE____**DATE**____________________________________