

Medical History

Chart #: _____

Name: _____ Male Female Ht: _____ Wt: _____

Occupation: _____ D.O.B. _____ Age: _____

Your medical history is important to us. Please circle Y or N for yourself, or F if a blood relative has/had these problems:

Anemia	Y N F	Bleeding ulcer	Y N F	HIV/AIDS	Y N F
Bleeding disorders	Y N F	Bowel Disorders	Y N F	TB	Y N F
Clotting disorders	Y N F	Stomach Disorders	Y N F	Hepatitis A B C	Y N F
Sickle Cell	Y N F	Bladder Disorders	Y N F		
		Liver /Cirrhosis	Y N F	Migraine Headaches	Y N F
Asthma	Y N F	Diabetes	Y N F	Glaucoma	Y N F
Bronchitis	Y N F	Years? _____		Hearing Loss	Y N F
Emphysema	Y N F	Renal Disease	Y N F	Vision Legally Blind	Y N F
COPD	Y N F	Dialysis	Y N F	Macular Degeneration	Y N F
Pneumonia	Y N F	Hemodialysis / Peritoneal			
Sleep Apnea	Y N	Transplant When? _____		<i>Environmental Allergies:</i>	
CPAP	Y N	What? _____		Latex	Y N F
		Thyroid Disorders	Y N F	Iodine	Y N F
High Blood Pressure	Y N F	Cancer	Y N F	Contrast Dye (IV)	Y N F
Heart Palpitations	Y N F	Where/When? _____			
Rapid Heart beat	Y N F			<i>Substance Use:</i>	
Angina/Chest Pain	Y N F	Fibromyalgia	Y N F	Alcohol	Y N F
MI/Heart Attack	Y N F	Lupus	Y N F	Amount: _____ Daily _____ Weekly	
When? _____		Psoriasis	Y N F	Tobacco/Chew	Y N F
Pacemaker	Y N F	Rheumatoid Arthritis	Y N F	Amount: _____ Pk/day	
Cardiac Surgery	Y N F	Osteoarthritis	Y N F	Former use-Quit when? _____	
Stroke/TIA's	Y N F	Other types arthritis	Y N F	Marijuana	Y N F
Malignant Hyperthermia	Y N F	Gout	Y N F	Heroin Cocaine/Crack	Y N F
ADD / ADHD	Y N F	Osteoporosis	Y N F		
Depression	Y N F				
Psychiatric Disorders	Y N F				
Currently Pregnant	Y N				
How many pregnancies? _____					

Medications: Please list **ALL Prescription, over the counter, and herbal/vitamin supplements** you take (name, strength, how often per day): _____

Medication **ALLERGIES**: NO YES-List name and type of reaction _____

Surgeries: Please list all surgeries you have **EVER** had and year done: _____

The information given above is accurate to the best of my knowledge. I realize it is my responsibility to inform my physician if there are changes in my medical history (i.e. new medications, allergies, additional medical problems or surgeries)

Patient Signature: _____

Date: _____

I have reviewed the above information

Physician Signature: _____

Date: _____

UPDATED/REVIEWED _____ Date: _____