Medical History

Patient ______________________________ Date ______________
Name of Physician ______________________________ Phone # ______________
Clinic or Facility Name ______________________________
Who may we notify in case on emergency
Name ______________________________ Relationship to you ______________

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 you treatment ______________________________

Yes ***No*** Have you had any Medical treatment or Physician visit of any kind the last two years?
If yes, describe ______________________________
Yes ***No*** Have you had any surgical operations 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 treatments?
If yes, 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
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
Yes ***No*** Hepatitis
Yes ***No*** Ulcers
Yes ***No*** Kidney Disorder
Yes ***No*** Tuberculosis
Yes ***No*** Enzyme Deficiency
Yes ***No*** HIV
Yes ***No*** Hydrocephalus
Yes ***No*** Anorexia, Bulimia
Yes ***No*** Chemical Dependency
Yes ***No*** Chronic Diarrhea
Yes ***No*** Thyroid Condition
Yes ***No*** Venereal Disease – Herpes II
Yes ***No*** Acquired Immune
Yes ***No*** Acquired Immune Deficiency Syndrome
Yes ***No*** Pacemaker Type
Yes ***No*** Hip or Joint Replacement
Yes ***Nka*** Allergy
Yes ***No*** Radiation or Chemical Therapy
Yes ***No*** Ear Infections
Yes ***No*** Chronic Sinus
Yes ***No*** Asthma
Yes ***No*** Hemophilia, Bleeding or Blood Disorder
Yes ***No*** Aids Related Complex
Yes ***No*** Heart Murmur
Yes ***No*** Hypothermia
Yes ***No*** Mitral Value Prolapse

Yes ***No*** **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
Yes ***No*** 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 ______ / ________

Signature ______________________________ **Date** ______________

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