



MEDICAL HISTORY

Please check correct response and indicate any medications taken where appropriate.

Patient's Name _____
 Name of Medical Doctor _____
 Date of last physical examination _____

	Yes	No
Are you presently under the care of a physician? _____ If so, for what? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any change in your health within the past year? _____	<input type="checkbox"/>	<input type="checkbox"/>
What medications are you taking? _____ _____		
Allergy to penicillin, or other antibiotics? _____ Please specify _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to latex? _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur _____	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart ailments, disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery _____	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulant therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding from a cut, surgery, or extraction _____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia, blood problems, leukemia _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever required a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>
Prosthetic joint surgery _____	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema, asthma _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke or use tobacco of any kind? _____	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Ulcer, colitis _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney trouble, dialysis _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorder _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes _____ How is it controlled? _____	<input type="checkbox"/>	<input type="checkbox"/>
Long-term steroid therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
Hormone Therapy (incl. birth control pill) _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, rheumatism _____	<input type="checkbox"/>	<input type="checkbox"/>
Eye disorders, glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells, epilepsy, convulsions _____	<input type="checkbox"/>	<input type="checkbox"/>
Neurological problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Care _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism, drug abuse _____	<input type="checkbox"/>	<input type="checkbox"/>
Malignancies _____	<input type="checkbox"/>	<input type="checkbox"/>
Radiation treatments/chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
Venereal disease, Herpes _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any reason to believe that you may have been exposed to HIV, the virus that causes AIDS? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant? _____ If so, what month? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed? _____ If so, explain _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had:		
1. Exposure to a person with tuberculosis? _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>
3. A positive skin test for tuberculosis? _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had a chest x-ray follow up? _____	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's Signature _____

The undersigned agrees that the information above is accurate.

HEALTH STATUS CHANGES

Date	Change in Health Status	Blood Pressure	Patient's Signature	Reviewed By
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