Medical History

Circle "YES" or "NO" to indicate if you have had any of the following:

AIDS/HIV	Yes/No	Chemical Dependency	Yes/No	Gout	Yes/No	Neuropathy	Yes/No	Special Diet	Yes/No
Allergies	Yes/No	Chest Pain	Yes/No	Headaches	Yes/No	Osteoporosis	Yes/No	Stroke	Yes/No
Allergies or anesthetics	Yes/No	Chronic Diarrhea	Yes/No	Heart Disease	Yes/No	Pulmonary Embolism	Yes/No	Swelling of Feet	Yes/No
Angina	Yes/No	Circulatory problems	Yes/No	Hemophilia	Yes/No	Psychiatric Care	Yes/No	Swollen Neck	Yes/No
Arthritis	Yes/No	Diabetes	Yes/No	Hepatitis or Jaundice	Yes/No	Radiation Treatment	Yes/No	Thyroid Disease	Yes/No
Artificial heart valves	Yes/No	Ear Problems	Yes/No	High Blood Pressure	Yes/No	Rash	Yes/No	Tuberculosis	Yes/No
Asthma	Yes/No	Epilepsy	Yes/No	Irregular Heart Beat	Yes/No	Respiratory Disease	Yes/No	Ulcers	Yes/No
Back Problems	Yes/No	Eye problems	Yes/No	Kidney Problems	Yes/No	Rheumatic Fever	Yes/No	Varicose Veins	Yes/No
Bleeding Disorders	Yes/No	Fainting	Yes/No	Liver Disease	Yes/No	Shortness of Breath	Yes/No	Venereal Disease	Yes/No
Cancer	Yes/No	Foot or Leg Cramps	Yes/No	Low Blood Pressure	Yes/No	Sinus Problems	Yes/No	Weight Loss	Yes/No

List all Allergies you may have to medications, foods, etc:

_____

=

List all medications (prescription & non-prescription) you take regularly

Name, Strength or Dose:	How Often	Name of Doctor who prescribed medication.

Surgeries: Please check and date all that apply to you (indicate LEFT or RIGHT)

	None		Arm		C-section
	Appendectomy		Elbow		Hysterectomy
	Colon Surgery		Shoulder		Other-Please explain
	Gall Bladder		Hip		
	Hernia Repair		Knee		
	Cardiac Bypass		Leg		
	Pain Management		Foot/Toes		
	Hand/Fingers		Neck		
	Wrist		Spine/Back		

Have you ever been admitted to a hospital? Please date and reason

_____

=