

MEDICAL HISTORY FORM

Name: Date: _____

Date: _____

Date of Birth: _____

Sex: M / F

Height: _____ Weight: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

- 1. Are you in good health? Yes No
2. Has there been any change in your health in the past year? Yes No
3. My last physical exam was on / /
4. Are you now under the care of a physician? Yes No
If so, for what condition?
5. The name and address of my physician is:
6. Have you had any serious illness, operation or hospitalization within the past 5 years? Yes No
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? Yes No
8. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills Yes No
If so, please list
9. Do you have or have you had any of the following diseases or problems?
a. Damaged heart valves, artificial valves or heart murmur Yes No
b. Rheumatic Heart Disease Yes No
c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition Yes No
1. Chest pain upon exertion? Yes No
2. Shortness of breath after mild exercise? Yes No
3. Do your ankles swell? Yes No
d. Allergies Yes No
e. Sinus trouble Yes No
f. Asthma or hay fever Yes No
g. Fainting spells or seizures Yes No
h. Diabetes Yes No
i. Hepatitis, jaundice or liver disease Yes No
j. Frequent or recurring mouth sores Yes No
k. Thyroid problems Yes No
l. Respiratory problems, emphysema, bronchitis, etc. Yes No
m. Arthritis or painful, swollen joints including jaw joint (TMJ) Yes No
n. Stomach ulcer or hyperacidity Yes No
o. Kidney trouble Yes No
p. Tuberculosis Yes No
q. Persistent cough or cough that produces blood Yes No
r. Persistent swollen neck glands Yes No
s. Low blood pressure Yes No
t. Epilepsy or neurological disorder Yes No
u. Are you taking vitamins or homeopathic remedies Yes No
v. Cancer Yes No
w. Any disease, drug or transplant operation that has depressed your immune system Yes No
10. Have you had abnormal bleeding? Yes No
a. Have you ever required a blood transfusion? Yes No
11. Do you have any blood disorder such as anemia? Yes No
12. Have you ever had treatment for a tumor or growth? Yes No
13. Are you allergic to or have you had a reaction to:
a. Local anesthetics Yes No
b. Penicillin or antibiotics Yes No
c. Sulfa drugs Yes No
d. Barbiturates or sleeping pills Yes No
e. Aspirin Yes No
f. Iodine Yes No
g. Codeine or other narcotics Yes No
h. Latex or rubber products Yes No

