

MEDICAL HISTORY

NAME _____ PREFERRED NAME _____

AGE _____ MALE FEMALE BLOOD PRESSURE _____

LUPUS YES NO

POSITIVE TEST FOR HIV YES NO

HEPATITS YES NO

STROKE YES NO

ARTHRITIS YES NO

DIABETES YES NO

EPILEPSY YES NO

HEART TROUBLE YES NO

RHEUMATIC FEVER YES NO

RHEUMATIC HEART DISEASE YES NO

HEART MURMUR YES NO

KIDNEY DISEASE YES NO

LIVER DISEASE YES NO

TUBERCULOSIS YES NO

EMPHYSEMA YES NO

HIGH BLOOD PRESSURE YES NO

RADIATION THERAPY BY X-RAY YES NO

CHEMOTHERAPY YES NO

ULCERS OR STOMACH TROUBLE YES NO

ASTHMA YES NO

GLAUCOMA YES NO

THYROID OR PARATHYROID DISORDER YES NO

CONTACT LENS YES NO

FAMILY HISTORY OF DIABETES YES NO

DO YOU BLEED EASILY? YES NO

DO YOU BRUISE EASILY? YES NO

ARTIFICIAL JOINT YES NO

PAST SURGERY YES NO

CURRENT SERIOUS ILLNESS?

DATE AND REASON FOR LAST PHYSICAL EXAMINATION:

PRESENTLY UNDER CARE OF DR. _____

FOR TREATMENT OF _____

PLEASE SIGN TOP LINE:

PATIENT SIGNATURE: _____ DATE: _____

PATIENT NAME: _____ DATE: _____

DRUG ALLERGY YES NO

REACTION _____

WHEN _____

FOOD OR POLLEN ALLERGY YES NO

REACTION _____

WHEN _____

TAKING TRANQUILIZERS YES NO

TAKING STEROIDS YES NO

CURRENT MEDICATIONS

PRESCRIBED DOSAGE

OVER THE COUNTER DOSAGE

ANY DRUG DEPENDENCY? YES NO

RECENT WEIGHT CHANGE? YES NO

FREQUENT URINATION YES NO

OFTEN THIRSTY? YES NO

OFTEN EXHAUSTED OR FATIGUED YES NO

SUBJECT TO FREQUENT HEADACHES YES NO

A NERVOUS PERSON YES NO

CURRENTLY IN GOOD HEALTH YES NO

TAKING ANTI-PREGNANCY DRUGS YES NO

PRESENTLY IN MEOPAUSE YES NO

IN POST-MEOPAUSE YES NO

PREGNANT YES NO

NURSING YES NO

DO YOU SMOKE? YES NO

DRINK ALCOHOLIC BEVERAGES YES NO

MITRAL VALVE PROLAPSE YES NO