

# MEDICAL HEALTH HISTORY

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Are you currently being treated for any medical condition? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, what is the condition being treated? _____                     |                          |                          |
| 2. Have you ever been hospitalized or had a serious illness? .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain _____   |                          |                          |
| 3. (Women) Are you pregnant? If so, give due date _____               | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you use tobacco in any form? If yes, how much _____             | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcoholic beverages (more than 2 drinks per day)? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have or have you ever had any of the following?             |                          |                          |

GENERAL	YES	NO	RESPIRATORY	YES	NO	BONE/ MUSCLES	YES	NO
Tire easily, weakness .....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/ rheumatism .....	<input type="checkbox"/>	<input type="checkbox"/>
Marked weight change .....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints/ limbs .....	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats .....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/ hay fever .....	<input type="checkbox"/>	<input type="checkbox"/>	(hip replacement, etc.)		
Persistent fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough .....	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>SKIN</b>			Difficulty breathing lying down	<input type="checkbox"/>	<input type="checkbox"/>	<b>DIGESTIVE SYSTEM</b>		
Eruptions (rash) hives .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>ENDOCRINE</b>			Hepatitis .....	<input type="checkbox"/>	<input type="checkbox"/>
Change in skin color .....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>EYES</b>			Family history of diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>
Visual change .....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid condition/ goiter .....	<input type="checkbox"/>	<input type="checkbox"/>	Change in appetite .....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>	Other .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>URINARY</b>		
<b>EARS</b>			<b>HEART/ BLOOD VESSELS</b>			Kidney disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hearing .....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>BLOOD</b>		
<b>NOSE</b>			Chest pain/ discomfort .....	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily .....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack/ trouble .....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems .....	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath .....	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>THROAT</b>			Swelling of ankles .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>OTHER</b>		
Soreness/ hoarseness .....	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>NERVOUS SYSTEM</b>			Congenital heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy .....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths .....	<input type="checkbox"/>	<input type="checkbox"/>
Headaches .....	<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve .....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/ epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ .....	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/ tingling .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery .....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS .....	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/ fainting .....	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding from cut ...	<input type="checkbox"/>	<input type="checkbox"/>			
Psychiatric treatment .....	<input type="checkbox"/>	<input type="checkbox"/>						
<b>Notes:</b> _____								
_____								
_____								

Are you ALLERGIC or have you ever experienced any reaction to the following?

- |  | YES                      | NO                       |                                   | YES                      | NO                       |                       | YES                      | NO                       |
|--|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|
| Local anesthetics (e.g. novocaine) ..... | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin .....                     | <input type="checkbox"/> | <input type="checkbox"/> | Codeine .....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa drugs .....                        | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin/ other antibiotics ... | <input type="checkbox"/> | <input type="checkbox"/> | Other allergies _____ |                          |                          |

Are you taking any of the following?

- |                                     | YES                      | NO                       |   | YES                      | NO                       |                                     | YES                      | NO                       |
|-------------------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|
| Antibiotics/ sulfa drugs .....      | <input type="checkbox"/> | <input type="checkbox"/> | Tranquilizers .....                                   | <input type="checkbox"/> | <input type="checkbox"/> | Blood thinners .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Insulin/ other diabetes drugs ..... | <input type="checkbox"/> | <input type="checkbox"/> | Blood pressure medication ...                         | <input type="checkbox"/> | <input type="checkbox"/> | Recreational drugs .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid medicine .....              | <input type="checkbox"/> | <input type="checkbox"/> | Digitalis/ heart medications ...                      | <input type="checkbox"/> | <input type="checkbox"/> | Cortisone/ steroids .....           | <input type="checkbox"/> | <input type="checkbox"/> |
| Nitroglycerin .....                 | <input type="checkbox"/> | <input type="checkbox"/> | Antihistamines/ allergy drugs/<br>cold remedies ..... | <input type="checkbox"/> | <input type="checkbox"/> | Bisphosphonates/ Osteoporosis ..... | <input type="checkbox"/> | <input type="checkbox"/> |

List **name** of ALL medications and **dosage** below:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

