Medical History

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Name: _____

Are you currently under the care of a Physician? ..... ☐ Yes ☐ No

For what reason? _____

_____

Physician's name: _____

Phone: _____

Address: _____

_____

When was your last physical exam? _____

Have you been hospitalized in the past 2 years? ..... ☐ Yes ☐ No

If yes, for what reason? _____

Do you smoke or use Tobacco? ..... ☐ Yes ☐ No

Frequency: _____

Emergency Contact: _____

Relationship: _____

Phone: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL CONDITIONS?

PLEASE MARK YES OR NO FOR EACH

Abnormal Bleeding ..... ☐ Yes ☐ No
Alcohol Abuse ..... ☐ Yes ☐ No
Allergy to Household Bleach ..... ☐ Yes ☐ No
Anemia ..... ☐ Yes ☐ No
Angina Pectoris ..... ☐ Yes ☐ No
Arthritis ..... ☐ Yes ☐ No
Artificial Heart Valve ..... ☐ Yes ☐ No
Artificial Joints ..... ☐ Yes ☐ No
Asthma ..... ☐ Yes ☐ No
Blood Transfusion ..... ☐ Yes ☐ No
Cancer-Chemotherapy ..... ☐ Yes ☐ No
Circulatory Problem ..... ☐ Yes ☐ No
Colitis ..... ☐ Yes ☐ No
Cosmetic Surgery ..... ☐ Yes ☐ No
Diabetes ..... ☐ Yes ☐ No
Drug Abuse ..... ☐ Yes ☐ No
Epilepsy-Seizures ..... ☐ Yes ☐ No
Fainting Spells/Dizziness ..... ☐ Yes ☐ No
Fever Blisters-Mouth ..... ☐ Yes ☐ No
Frequent Headaches ..... ☐ Yes ☐ No
Glaucoma ..... ☐ Yes ☐ No
Growth on Head or Neck ..... ☐ Yes ☐ No
HIV + AIDS ..... ☐ Yes ☐ No
Hay Fever ..... ☐ Yes ☐ No
Heart Problems ..... ☐ Yes ☐ No
Hemophilia ..... ☐ Yes ☐ No
Hepatitis - Type _____ ..... ☐ Yes ☐ No
Herpes ..... ☐ Yes ☐ No
High Blood Pressure ..... ☐ Yes ☐ No
Jaundice ..... ☐ Yes ☐ No
Kidney Problems ..... ☐ Yes ☐ No
Liver Disease ..... ☐ Yes ☐ No
Low Blood Pressure ..... ☐ Yes ☐ No
Mitral Valve Prolapse ..... ☐ Yes ☐ No
Pace Maker ..... ☐ Yes ☐ No
Psychiatric Condition ..... ☐ Yes ☐ No
Radiation Therapy ..... ☐ Yes ☐ No
Respiratory Problems ..... ☐ Yes ☐ No
Rheumatic Fever ..... ☐ Yes ☐ No
Scarlet Fever ..... ☐ Yes ☐ No
Sinus Problems ..... ☐ Yes ☐ No
Special Diet ..... ☐ Yes ☐ No
Stroke ..... ☐ Yes ☐ No
Taken Fen-Phen ..... ☐ Yes ☐ No
Thyroid Problems ..... ☐ Yes ☐ No
Tuberculosis ..... ☐ Yes ☐ No
Ulcers ..... ☐ Yes ☐ No
Venereal Disease ..... ☐ Yes ☐ No
Weight Loss-Unexplained ..... ☐ Yes ☐ No

Other: _____

ALLERGIES

Aspirin..... ☐ Yes ☐ No
Codeine ..... ☐ Yes ☐ No
Dental Anesthetics ..... ☐ Yes ☐ No
Erythromycin..... ☐ Yes ☐ No
Jewelry ..... ☐ Yes ☐ No
Latex ..... ☐ Yes ☐ No
Metals ..... ☐ Yes ☐ No
Penicillin..... ☐ Yes ☐ No
Tetracycline..... ☐ Yes ☐ No

Other: _____

FOR WOMEN ONLY:

Are you taking Birth Control Pills?..... ☐ Yes ☐ No
Are you Nursing? ..... ☐ Yes ☐ No
Are you Pregnant? ..... ☐ Yes ☐ No
If yes, number of weeks: _____
Are you receiving Hormone Therapy? ..... ☐ Yes ☐ No
Are you receiving treatment for Osteoporosis/Osteopenia?..... ☐ Yes ☐ No

Please elaborate on any questions answered yes: _____

_____

_____

List all medications you are currently taking: _____

_____

_____

Signature: _____ Date: _____

UPDATES: PLEASE INITAL AND DATE

Initial Here	Date Here	Initial Here	Date Here	Initial Here	Date Here
Initial Here	Date Here	Initial Here	Date Here	Initial Here	Date Here