

Medical History

1. Are you in good health?€Yes €No
2. Has there been a change in your general health within the past year?.....€Yes €No
3. Are you under the care a physician?.....€Yes €No
4. If so, what condition is being treated? _____
5. Date of your last visit to your physician _____ Nature of visit _____
6. Your physician's name _____ Phone # _____
Address of physician _____
7. Have you ever been hospitalized or had a serious operation or illness within the last five years? €Yes €No
If so, for what? _____

8. Do you have, or have you had, any of the following diseases or problems? **Please check:**

Heart Failure	Kidney Trouble	Sinus Trouble	Nervousness/Anxiety
Emphysema	AIDS/HIV	Rheumatism	Chemotherapy (e.g. Cancer
Diabetes	Ulcers	Allergies or Hives	Leukemia)
Lupus	Cold Sores	Cortisone Medicine	Radiation Treatment (head, neck)
Thyroid disease	Bruise Easily	Scarlet Fever	Heart Disease or Attack
Angina Pectoris	STD or VD (e.g.	Artificial Joint	Mitral Valve Prolapse
Arthritis	Syphilis, Gonorrhea)	Glaucoma	Psychiatric Treatment
Tuberculosis (TB)	Hepatitis A, B, or C	Anemia	Fainting or Dizzy Spells
High Blood Pressure	Sickle Cell Disease	Pain in Jaw Joints	Artificial Heart Valve
Asthma	Blood Transfusion	Heart Pacemaker	Epilepsy or Seizures
Heart Murmur	Liver Disease	Stroke	Bleeding Disorder
Hay Fever	Yellow Jaundice	Heart Surgery	Rheumatic Fever
Jaundice	Respiratory Problems	Phen Fen (1 month +)	Stomach Problems

OTHER: _____

9. Are you taking any drugs, medicines, or vitamin supplements?.....€Yes €No
If so, please list _____
10. Are you allergic, or have you reacted adversely, to any drugs or medicine?€Yes €No

If so, which drugs? _____
€Aspirin €Erythromycin €Codeine €Local Anesthetic €Epinephrine €Latex
€Penicillin €Nitrous Oxide €Novocain or Xylocaine €Other: _____

11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest?€Yes €No
12. Do your ankles swell during the day? €Yes €No
13. Do you have a disease condition, or problem not listed above that you think I should know?€Yes €No
14. For women only: Are you pregnant? €Yes €No If so, what month? _____ Breast-feeding? €Yes €No
Are you taking birth control pills? €Yes €No

Family Physician _____ Phone # _____

Patient signature _____ Dr./ Team signature _____

Update signature and date _____

(Please continue on other side.)