

MEDICAL HISTORY

Patient's Name _____ Date _____

Name of Family doctor _____ Height: _____ Weight: _____

Reason for today's visit. Please list all related symptoms. _____

If any answers are Yes, please explain.

Have you been under a doctor's care in the past five years? Yes _____ No _____

Are you under medical treatment now? Yes _____ No _____

Are you taking prescription medication for any reason? Yes _____ No _____

Are you allergic to any medication? Yes _____ No _____

Have you had any complications from surgery or anesthesia? Yes _____ No _____

Do you use tobacco in any form? Yes _____ No _____

Do you have a history of any of the following? Does anyone in your family?

	Self	Family		Self	Family
Diabetes	Yes___ No___	Yes___ No___	Sinus Trouble	Yes___ No___	Yes___ No___
Heart Disease	Yes___ No___	Yes___ No___	High Blood Pressure	Yes___ No___	Yes___ No___
Stomach trouble	Yes___ No___	Yes___ No___	Kidney Disease	Yes___ No___	Yes___ No___
Arthritis	Yes___ No___	Yes___ No___	Excessive Bleeding	Yes___ No___	Yes___ No___
Lung Disease	Yes___ No___	Yes___ No___	Fainting Dizziness		
Rheumatic Fever	Yes___ No___	Yes___ No___	or Convulsions	Yes___ No___	Yes___ No___
Liver Disease	Yes___ No___	Yes___ No___	Breathing Problems	Yes___ No___	Yes___ No___
Eye Trouble	Yes___ No___	Yes___ No___	Are you pregnant?	Yes___ No___	

Is there any other medical information that we should know? Yes___ No___

Reviewed by: _____

Date _____ Initials _____

Updated/No Changes in medical history:

Date _____ Initials _____