

MEDICAL HISTORY

1. When was last physical exam?
2. Physician Name
- Address
3. Have you been a patient in the hospital during the past two years? Yes No
If yes, for what reason?
4. Have you ever been under the care of a medical doctor during the past two years? Yes No
If yes, what reason?
5. Have you taken any prescription medication during the past 12 months? Yes No
6. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine or
any drugs or medications? Yes No
If yes, please list
7. Are you allergic to any anesthetic? Yes No
8. Have you ever had any excessive bleeding requiring special treatment? Yes No
9. Check any of the following which you have had or have at present:

<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Heart Disease or Attack	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> X-Ray or Cobalt Treatment	<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Angina Pectoris (Chest Pain)	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Chemotherapy (Cancer, Leukemia)	<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea)
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Cortisone Medication	<input type="checkbox"/> Cold Sores or Fever Blisters
<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Cough	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Genital Herpes
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Artificial Heart Lesions	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> Fainting or Dizzy Spells
<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> HIV Positive (AIDS)	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Hepatitis A (Infectious)	<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Allergies or Hives	<input type="checkbox"/> Hepatitis B (Serum)	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Diabetes	<input type="checkbox"/> Bruise Easily
10. Do you smoke? How much? Yes No
11. Do you drink alcoholic beverages? Yes No
12. Do you use recreational drugs? Yes No
13. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath,
or because you are very tired? Yes No
14. Do your ankles swell during the day? Yes No
15. Have you lost or gained more than 10 pounds in the last year? Yes No
16. Do you use more than two pillows to sleep? Yes No
17. Do you ever wake up from sleep short of breath? Yes No
18. Are you on a special diet? Yes No
19. Has your medical doctor ever said you have a cancer or tumor? Yes No
20. Do you have any disease, condition or problem not listed? Yes No
21. List all medications you are taking at this time:
22. Women: Are you pregnant? Yes No If yes, what month are you due?
- Are you taking birth control pills? Yes No
(You should be aware that research has shown that certain antibiotics may alter the effectiveness of birth control pills)

I certify that the above information is complete and accurate

Patient's Signature (If child, signature of responsible person)

Date

MEDICAL ALERT