Patient Name _____ Age _____

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:

☐ Heart Failure	☐ Stroke	☐ Thyroid Disease	☐ Yellow Jaundice
☐ Heart Disease or Attack	☐ Kidney Trouble	☐ X-Ray or Cobalt Treatment	☐ Blood Transfusion
☐ Angina Pectoris (Chest Pain)	☐ Ulcers	☐ Chemotherapy (Cancer, Leukemia)	☐ Drug Addiction
☐ High Blood Pressure	☐ Bleeding Disorders	☐ Arthritis	☐ Hemophilia
☐ Heart Murmur	☐ Shortness of Breath	☐ Rheumatism	☐ Venereal Disease (Syphilis, Gonorrhea)
☐ Rheumatic Fever	☐ Emphysema	☐ Cortisone Medication	☐ Cold Sores or Fever Blisters
☐ Congenital Heart Lesions	☐ Cough	☐ Glaucoma	☐ Genital Herpes
☐ Scarlet Fever	☐ Tuberculosis (TB)	☐ Pain in Jaw Joints	☐ Epilepsy or Seizures
☐ Artificial Heart Lesions	☐ Asthma	☐ Cosmetic Surgery	☐ Fainting or Dizzy Spells
☐ Heart Pacemaker	☐ Hay Fever	☐ HIV Positive (AIDS)	☐ Nervousness
☐ Heart Surgery	☐ Sinus Trouble	☐ Hepatitis A (Infectious)	☐ Psychiatric Treatment
☐ Artificial Joint	☐ Allergies or Hives	☐ Hepatitis B (Serum)	☐ Sickle Cell Disease
☐ Anemia	☐ Diabetes	☐ Liver Diabetes	☐ 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