

MEDICAL HISTORY

Height _____

Weight _____

NAME _____ DATE _____ AGE _____

Personal - Family / Medical Dr. _____ Last exam _____

Specialists and specialty _____

Medication ALLERGIES and REACTION _____

Previous SUTURE REACTION? _____

Current MEDICATIONS: include DOSE & FREQUENCY _____

Previous SURGERIES and approximate DATES _____

Recent serious MEDICAL ILLNESSES and approximate dates _____

Family medical history: Father Living Deceased Cause of death _____

Mother Living Deceased Cause of death _____

Medical problems that run in your family _____

Circle one:

Yes No Bleeding tendencies? _____

Yes No Any reaction to general anesthesia, novocaine, xylocaine, soaps or iodine? _____

Yes No Blood Clots or deep venous thrombosis? _____

Yes No Are you on a special diet? _____

Yes No Do you or did you ever smoke? _____ How much and how long? _____ When quit _____

Yes No Do you drink alcohol? How much? _____

Yes No Do you wear glasses, contacts, or hearing aids? _____

Yes No Unexplained weight change? _____

Yes No Cancer or tumor? _____

Yes No Heart attacks, heart disease, shortness of breath, or chest pain? _____

Yes No Dizziness, fainting, seizures? _____

(Continued on the other side)

Yes No High blood pressure? _____

Yes No Liver problems or jaundice? _____

Yes No Kidney problems or recurrent urinary tract infections? _____

Yes No Diabetes? _____

Yes No Are your immunizations current? _____

CIRCLE any of the following which you have had or have at present:

- | | | |
|------------------------|--------------------------|---------------------|
| Heart Murmur | Congenital Heart Lesions | Scarlet Fever |
| Rheumatic Fever | Artificial Heart Valve | Heart Pacemaker |
| Irregular Heart Rhythm | Heart Surgery | Ulcers |
| Anemia | Stroke | Tuberculosis |
| Emphysema | Cough | Sinus Trouble |
| Asthma | Hay Fever | Chemotherapy |
| Thyroid Disease | Radiation Treatment | Blood Transfusion |
| Glaucoma | Hepatitis A or B | Auto Immune Disease |
| Fibromyalgia | Rheumatoid Arthritis | Skin Problems |

Other _____

To the best of my knowledge all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

Signature of Patient, Parent or Guardian