

# Medical Health History

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

## PATIENT MEDICAL HISTORY

PHYSICIAN \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_  
 DATE OF LAST EXAM \_\_\_\_\_ MEDICAL ALERTS \_\_\_\_\_

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Are you under medical treatment now?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or illness? If yes, please give details _____ | <input type="checkbox"/> | <input type="checkbox"/> |

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 3. Are you taking any medications including Non-prescription medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

If yes, what medications are you taking? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 4. Do you use tobacco?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcohol?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use cocaine or other drugs?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you wearing contact lenses?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you allergic to or have you had any reactions to the following? |                          |                          |

- WOMEN ONLY** YES NO
- A) Are you pregnant?
- B) Are you nursing?
- C) Are you taking birth control pills?

- |                                 | YES                      | NO                       |              | YES                      | NO                       |
|---------------------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|
| Local anesthetics               | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives    | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa drugs                     | <input type="checkbox"/> | <input type="checkbox"/> | Iodine       | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex                           | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin      | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine or other narcotics      | <input type="checkbox"/> | <input type="checkbox"/> | Other        | <input type="checkbox"/> | <input type="checkbox"/> |

**9. Do you have or have you had any of the following?**

- |                     | YES                      | NO                       |                     | YES                      | NO                       |                         | YES                      | NO                       |
|---------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|
| Heart Murmur        | <input type="checkbox"/> | <input type="checkbox"/> | Stroke              | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia      | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Replacement   | <input type="checkbox"/> | <input type="checkbox"/> | Covid 19            | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease          | <input type="checkbox"/> | <input type="checkbox"/> |
| Implant             | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever/allergies | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease           | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Fainting/seizures   | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis               | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease       | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis        | <input type="checkbox"/> | <input type="checkbox"/> | AIDS/HIV Infection      | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pains         | <input type="checkbox"/> | <input type="checkbox"/> | Asthma              | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Trans. Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack        | <input type="checkbox"/> | <input type="checkbox"/> | Anemia              | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems    | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Pacemaker   | <input type="checkbox"/> | <input type="checkbox"/> | Radiation therapy   | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems        | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever     | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/ Leukemia  | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Ulcers          | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure  | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema           | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____            |                          |                          |
| Diabetes            | <input type="checkbox"/> | <input type="checkbox"/> | Cancer              | <input type="checkbox"/> | <input type="checkbox"/> | _____                   |                          |                          |
| Leukemia            | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis           | <input type="checkbox"/> | <input type="checkbox"/> | _____                   |                          |                          |

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_