

MEDICAL HEALTH HISTORY



1. GENERAL HEALTH ? _____ Excellent _____ Good _____ Fair _____ Poor

2. If female, are you pregnant? _____ If yes, due date? _____

3. Who is your physician? _____

Address _____

Telephone number _____

4. When was your last complete physical examination? _____

5. Are you being treated for anything at this time? _____

6. Have you had any recent surgery? _____

7. Have you ever been treated with radiation? _____

8. Are you taking any medications? _____ If yes, please name: _____

9. Are you allergic to (please check):

_____ Penicillin _____ Codeine _____ "Novocaine"

_____ Other: _____

10. Are you subject to prolonged bleeding? _____

11. Do you smoke? _____ No _____ Yes, how much? _____

12. Did you ever have: (check each)

Yes

No

Yes

No

_____ Kidney Disease

_____ Epilepsy

_____ Rheumatic Fever

_____ Venereal Disease

_____ Heart Problems

_____ Hiv Positive

_____ Cancer

_____ Hepatitis

_____ Liver Disease

_____ Diabetes

_____ Anemia

_____ Thyroid Problems

_____ Tuberculosis

_____ Artificial Joints

_____ Asthma

_____ Heart Murmur

_____ Lymes Disease

_____ Abnormal Blood Pressure

13. Is there anything else about your medical history that you feel is important? _____

Date _____ Signature _____