

MEDICAL HISTORY FORM

Date _____

Name _____ Phone # _____

Address _____ Business Phone# _____

City _____ State _____ Zip Code _____

Occupation _____ Social Security # _____

Date of Birth _____ Sex M F Height _____ Weight _____ Single _____ Married _____

Name of Spouse _____ Closest Relative _____ Phone _____

If you are completing this form for another person, what is your relationship to that person? _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Yes No 1. Are you in good health?

Yes No 2. Has there been any change in your general health within the past year?

3. My last physical examination was on _____

Yes No 4. Are you under the care of a physician?

If so, what is the condition being treated? _____

5. The name and address of my physician is _____

Yes No 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?

If so, what was the illness or problem? _____

Yes No 7. Are you taking any medicine(s) including non-prescription medicine?

If so, what medicine(s) are you taking? _____

8. Do you have or have you had any of the following diseases or problems?

Yes No a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease?

Yes No b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, Coronary occlusion, high blood pressure, arteriosclerosis, stroke)

Yes No 1. Do you have chest pain upon exertion?

Yes No 2. Are you ever short of breath after mild exercise or when lying down?

Yes No 3. Do your ankles swell?

Yes No 4. Do you have inborn heart defects?

Yes No 5. Do you have a cardiac pacemaker?

Yes No c. Allergies?

Yes No d. Sinus trouble?

Yes No e. Asthma or hay fever?

Yes No f. Fainting spells or seizures?

Yes No g. Persistent diarrhea or recent weight loss?

Yes No h. Diabetes?

Yes No i. Hepatitis, jaundice, or liver disease?

Yes No j. AIDS or HIV infection?

Yes No k. Thyroid problems?

Yes No l. Respiratory problems, emphysema, bronchitis, etc.?

Yes No m. Arthritis or painful swollen joints?

Yes No n. Stomach ulcer or hyperacidity?

Yes No o. Kidney trouble?

Yes No p. Tuberculosis?

Yes No q. Persistent cough or cough that produces blood?

Yes No r. persistent swollen glands in neck?

Yes No s. Low blood pressure

Yes No t. Sexually transmitted disease?

Yes No u. Epilepsy or other neurological disease?

Yes No v. problems with mental health?

Yes No w. Cancer?

Yes No x. Problems of the immune system?

Yes No y. Night sweats, fatigue, general malaise?

