

PATIENT _____

MEDICAL HEALTH HISTORY

Please answer the following **CONFIDENTIAL** questions and briefly explain your answers.

Physician _____ City _____ Phone _____

Date of last physical exam _____ Height _____ Weight _____

Date of last visit to M.D. _____ Why? _____

Please check the appropriate box in answer to the following questions:

**DO YOU TAKE ANY BLOOD
THINNING MEDICATION
INCLUDING ASPIRIN?**

YES NO ?

Are you in good health?

If no, what is the nature of problem? _____

Are you **now** being treated by a physician or psychiatrist?

If yes, what for? _____

Are you taking **any** drugs or medication?

If yes, what? _____

Have you ever been seriously ill or hospitalized?

If yes, when and what for? _____

Have you had excessive bleeding requiring special treatment?

If yes, give details: _____

Do you use **tobacco**? If yes check kind: cigarettes pipe chewing
 cigars snoose or snuff

Are you allergic, or have you experienced any unusual reaction to any drugs?

penicillin codeine aspirin tranquilizers barbiturates

dental anesthetics other?

Specify: _____

Has anyone in your family ever had diabetes? If yes, who? _____

Is there a tendency towards any illness in your family?

If yes, give details: _____

Women: are you pregnant? If yes, what is your due date? _____

Do you wear contact lenses?

If you have ever had any of the following, please check:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Blood problems | <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Chest pains on exertion | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Lung problems, T.B. | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric therapy |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Sinus problems/hay fever | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Periods of depression |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver disorder | <input type="checkbox"/> Cancer or tumor | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Hepatitis, jaundice | <input type="checkbox"/> Radiation treatment | Have you been diagnosed for |
| <input type="checkbox"/> Difficult breathing | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy or convulsions | AIDS/HIV Positive YES/NO |

If you have any disease, condition, problem or impending operation(s) not listed above that I should know about, give details:

(Signature of patient, parent or guardian)

(Date)

PLEASE INFORM US IF YOUR HEALTH CHANGES IN ANY WAY

DOCTOR'S USE:

HEALTH CHANGE _____ DATE _____

HEALTH CHANGE _____ DATE _____

HEALTH CHANGE _____ DATE _____

HEALTH CHANGE _____ DATE _____