MEDICAL HISTORY

CIRCLE

1. Have you ever been a patient in the hospital within the past two years? YES NO
2. Have you been under the care of a medical doctor within the past two years? YES NO
3. Are you taking any pills, medications or drugs (including aspirin/ASA) or other non-prescription drugs? List: _____ YES NO

_____

4. What is the name of your pharmacy? _____
5. When was your last physical examination? _____
6. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any other drugs or medications? YES NO

_____

7. Have you ever had any excessive bleeding requiring special treatment? YES NO
8. Do you smoke or chew tobacco? Current: YES NO Previous: YES NO Never: YES NO
If so, how much? _____
9. Do you use recreational drugs? Current: YES NO Previous: YES NO Never: YES NO
If so, how often? _____ What kind? _____
10. Circle any of the following which you have had or have at present:

Heart Failure Emphysema HIV Positive
Heart Disease or Attack Persistent Cough Hepatitis Type A (Infectious)
Ulcers Hay Fever B (serum), C or D
Angina Pectoris Tuberculosis (TB) Liver Disease
High Blood Pressure Asthma Yellow Jaundice
Low Blood Pressure AIDS Blood Transfusion
Rheumatic Fever Hemophilia Bruise Easily
Rheumatic Heart Disease Sinus Trouble Venereal Disease (Syphilis, Gonorrhea)
Heart Murmur Allergies or Hives Drug Addiction
Congenital Heart Defect Diabetes , recent AIC Cold Sores
Scarlet Fever Thyroid Disease Genital Herpes
Artificial Heart Valve X-Ray or Radiation Therapy Epilepsy or Seizures
Heart Pace Maker Chemotherapy, (Cancer, Leukemia) Fainting or Dizzy Spells
Heart Surgery Arthritis Nervousness
Artificial Joint Rheumatism Psychiatric Treatment
Anemia Cortisone Medicine (Steroids) Sickle Cell Disease
Stroke Glaucoma
Pain in Jaw Joints

11. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? YES NO
12. Do your ankles swell during the day? YES NO
13. Do you use more than 2 pillows to sleep? YES NO
14. Do you ever wake up from sleep short of breath? YES NO
15. Has your medical doctor ever said you have cancer or a tumor? YES NO
16. Do you have any disease, condition, or problem not listed? YES NO

_____

17. Are you under abnormal stress? (for example, marital, business or social)? YES NO
18. WOMEN: Are you pregnant now? YES NO

Are you taking oral contraceptives? (Birth Control Pills) YES NO
Do you anticipate becoming pregnant? YES NO
Have you reached menopause? YES NO
To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change
in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

_____ _____
Date Signature of Patient, Parent or Guardian