MEDICAL HISTORY

Patient's Name____ Date______________
First Middle Last

Name of physician______________________________ Address______________________

Date of last health examination____________________ For what______________________

Findings at that time____

What is your height______________________ What is your weight____________________

Are you in good health	Yes___ No___	Are you under any medical care	Yes___ No___
Are you pregnant (females)	Yes___ No___	Are you taking any medications	Yes___ No___
Have you ever had:		Have you ever been hospitalized	Yes___ No___
A.I.D.S.	Yes___ No___	Are you prone to:	
Anemia	Yes___ No___	Colds	Yes___ No___
Asthma or Hay Fever	Yes___ No___	Sore throats	Yes___ No___
Bone disorders	Yes___ No___	Ear infections	Yes___ No___
Cancer	Yes___ No___	Are you allergic to:	
Diabetes	Yes___ No___	Penicillin	Yes___ No___
Epilepsy or Convulsions	Yes___ No___	Local anesthetics	Yes___ No___
Endocrine disorders	Yes___ No___	Other (medications, dust, etc.)	Yes___ No___
Genital herpes	Yes___ No___	Have you ever had:	
Gonorrhea	Yes___ No___	Abnormal blood pressure(high,low)	Yes___ No___
Heart murmur	Yes___ No___	Abnormal heart conditions	Yes___ No___
Hepatitis	Yes___ No___	Adenoids removed (at what age___)	Yes___ No___
Kidney disorders	Yes___ No___	Tonsils removed (at what age___)	Yes___ No___
Liver disorders	Yes___ No___	Any operations	Yes___ No___
Mental disorders	Yes___ No___	Behavioral problems	Yes___ No___
Nervous disorders	Yes___ No___	Broken bones	Yes___ No___
Oral herpes (cold sores)	Yes___ No___	Difficulty breathing	Yes___ No___
Pneumonia	Yes___ No___	Fainting or dizziness	Yes___ No___
Rheumatic fever	Yes___ No___	Nausea or Vomiting	Yes___ No___
Syphilis	Yes___ No___	Prolonged bleeding from a cut	Yes___ No___
Thyroid disorders	Yes___ No___	Recent gain or loss in weight	Yes___ No___
Tuberculosis	Yes___ No___	Other conditions or illnesses	Yes___ No___

If yes to any of the above, please give details (dates, names, reasons, prescribing doctor, etc.)____

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