MEDICAL HISTORY

Date: _____

Name: _____ Sex: M___ F___ Date of Birth: _____

PAST MEDICAL HISTORY: (have you ever had any of the following: (circle))

High Blood Pressure	Asthma	Hepatitis	Arthritis
Heart Attack/Angina	Tuberculosis	Kidney Disease/Stone	Heart Murmur
Stroke or TIA	Phlebitis	Stomach Ulcer	Migraine Headache
Diabetes	Bleeding Disorder	Crohn's Disease	Seizures
Rheumatic Fever	Sickle Cell Anemia	Thyroid Disease	Anxiety
Pneumonia	Blood Transfusion	Cancer	Glaucoma
Emphysema/COPD	Gallstones	Cataracts	HIV
High Cholesterol	Prostate Trouble	Depression	Lupus

Other serious illnesses: _____

OPERATIONS (give date or age)

Tonsils	Gallbladder	Kidney	Biopsy
Appendix	Stomach	Hysterectomy	Prostate
Hernia	Heart	Hip	Knee
Back Surgery		Neck Surgery	

Other surgeries/Serious accidents/Injuries or Hospitalizations:

_____

CURRENT MEDICAL OR PSYCHOLOGICAL PROBLEMS (list all conditions for which you are currently treated)

_____

_____

_____

_____

_____

CURRENT MEDICATIONS: (Include Non-Prescription Drugs, Vitamins, Laxatives, Herbs)

Medication/Drug:	Amount or Dose:	Frequency:

Are you currently taking a blood thinning medication? (If so, which one) _____

ALLERGIES: (Medication/Food/Pollen/ETC.)

_____

_____

HABITS (Do you or have you ever used?)

	YES	NO	AMOUNT/TYPE	DATE WHEN STOPPED
Drugs (marijuana/cocaine)				
Tobacco (cigarettes/dip/cigars)				
Alcohol (beer/wine/liquor)				
Caffeine (cola/coffee/tea)				
Diet (restrictions/special diet)				
Exercise Regularly				

FAMILY HISTORY **********	Age	Alive	Deceased	Health Problems
Father				
Mother				
Brother				
Brother				
Sister				
Sister				
Children				