

Medical History Form

Date _____

Name _____
Last First Middle

Date of Birth ____ / ____ / ____ Sex M F
mo. day yr.

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.

- | | | |
|--|-----|----|
| 1. Are you in good health? | Yes | No |
| 2. Has there been any change in your general health within the past year? | Yes | No |
| 3. My last physical examination was on _____ | | |
| 4. Are you under the care of a physician? | Yes | No |
| If so, what is the condition being treated? _____ | | |
| 5. The name and address of my physician(s) is _____

_____ | | |
| 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? | Yes | No |
| If so, what was the illness or problem? _____ | | |
| 7. Are you taking any medicine(s) including non-prescription medicine? | Yes | No |
| If so, what medicine(s) are you taking? _____ | | |
| 8. Do you have or have you had any of the following diseases or problems? | | |
| 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. Allergy | 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 |

(over)

