Date______________

Medical History Form

Name____
(Last) (First) (Middle)

Address____
City________________ State_______ Zip__________

Date of Birth______________

Height_____________ Weight____________ Sex M F Single___ Married___

Name of Spouse________________ Closest relative_______________
Phone___________________

---

1. Are you under the care of a physician, for what condition? Y N

   ____

   Name and phone number of Physician __________________________________

   Address ____
2. List any Major surgeries you have had _____________________________________

____
3. Have you had any joint replacement surgery Y N ___________________________
4. Do you use any tobacco products Y N_______________________________
5. 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____ Y N

   b. Cardiovascular disease (heart attack, angina, high blood pressure, arteriosclerosis, stroke)____ Y N

      1.chest pain on exertion_____________________________ Y N

      2. Shortness of breath ______________________________ _Y N

      3. Do your ankles swell? ____________________________ Y N

      4. Inborn heart defects ______________________________ _ Y N

      5. cardiac pacemaker ________________________________ Y N

   c. Allergy ____Y N

   d. Sinus trouble ____ _Y N

   e. Asthma ____Y N

   f. Seizures ____Y N

   g. Diabetes ____ Y N

   h. Hepatitis, or liver disease _________________________________ Y N

   i. Respiratory problems, emphysema, bronchitis, etc ______________Y N

   j. Cancer, or treatment for any tumor or growth __________________Y N

   ____

6. Have you had any abnormal bleeding ______________________________Y N

7. **Are you allergic, or have you had a reaction to**:

a. Local anesthetics ____ Y N
b. Penicillin ____ Y N
c. Other antibiotics ____ Y N
d. Sulfa ____ Y N
e. Barbiturates, sedatives or sleeping pills _______________________ Y N
f. Aspirin ____ Y N
g. Iodine ____ Y N
h. Codeine ____ Y N
i. Other ____ Y N

Women:

16. Are you pregnant? ____ Y N
17. Are you nursing? ____ Y N
18. Are you taking birth control pills? ___________________________ Y N

Are you taking any medications? Please list all medications: ________________

____
____
____

Signature of Patient or Guardian ________________________ Date ____________

Medical History Update:

Date	Comments	Signature