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MEDICAL HISTORY

DATE: ___/ ___/ ____

DATE OF BIRTH ____

DATE OF LAST HEALTHCARE EXAMINATION ____

ARE YOU UNDER MEDICAL CARE AT PRESENT? ___________ FOR WHAT? _________________________

ARE YOU TAKING ANY MEDICATION? ____

ARE YOU ALLERGIC TO ANY DRUGS? __________________ WHICH? ______________________________

DO YOU HAVE OR HAVE YOU EVER HAD?

	YES	NO		YES	NO
HEART TROUBLE	______	______	AIDS	______	______
ABNORMAL BLOOD PRESSURE	______	______	BEEN EXPOSED TO A PERSON WITH AIDS/HIV	______	______
DIABETES	______	______	VENEREAL DISEASE	______	______
			TUBERCULOSIS	______	______
EPILEPSY	______	______	ABNORMAL BLEEDING	______	______
HEPATITIS	______	______	ULCER	______	______
RHEUMATIC FEVER	______	______	CANCER OR TUMOR	______	______
HEART MURMER	______	______	ARE YOU ALLERGIC TO		
PACEMAKER	______	______	PENICILLIN	______	______
MAJOR OPERATIONS	______	______	LOCAL ANESTHETIC:	______	______
ANEMIA	______	______	WOMEN ARE YOU PREGNANT	______	______

ANY COMMENTS YOUR WISH TO MAKE ABOUT YOUR HEALTH ___________________________________

ARE YOU IN GOOD HEALTH? ____

Signature: _________________________________