MEDICAL HISTORY

NAME _____ DATE _____

DATE OF YOUR LAST PHYSICAL EXAMINATION _____ WEIGHT _____ HEIGHT _____

ALL PREVIOUS SURGERY (INCLUDING COSMETIC SURGERY)

	TYPE	DATE	COMPLICATIONS OR DIFFICULTIES
1.			
2.			
3.			

MEDICAL PROBLEMS OR CONDITION NOW UNDER TREATMENT BY A PHYSICIAN

EXPLAIN: _____

ADMISSIONS TO HOSPITAL

	REASON	DATE	COMPLICATIONS OR DIFFICULTIES
1.			
2.			

MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE NOW

	TYPE	DOSAGE/AMOUNT IF KNOWN	TAKE HOW OFTEN
1.			
2.			
3.			

CONSUMPTION OF THE FOLLOWING

ASPIRIN: DAILY _____ WEEKLY _____ ALCOHOL: DAILY _____ WEEKLY _____ TOBACCO: DAILY _____ WEEKLY _____

BLEEDING PROBLEMS

DO YOU BRUISE OR BLEED EASILY (CUTS, TOOTH EXTRACTIONS, PREGNANCY)? YES NO EXPLAIN: _____

DO YOU HAVE A FAMILY HISTORY OF BLEEDING PROBLEMS? EXPLAIN: _____

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA

EXPLAIN: _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO **ARE YOU PREGNANT?** YES NO

HAVE YOU EVER BEEN EXPOSED TO (PLEASE CIRCLE YES OR NO)

YES	NO	INTRAVENOUS DRUGS	YES	NO	TB	YES	NO	HEPATITIS	YES	NO	BLOOD TRANSFUSION
YES	NO	INFECTIOUS DISEASES	YES	NO	AIDS	YES	NO	HIV	YES	NO	LIVER TRANSPLANT

IF YES TO ANY EXPLAIN: _____

HISTORY OF EPILEPSY OR MENTAL ILLNESS

EXPLAIN: _____

MEDICAL HISTORY

CHILDHOOD MEDICAL HISTORY (PLEASE CIRLE YES, NO OR UNCERTAIN)

HAD ALL KNOWN "BABY SHOTS"?	YES	NO	UNCERTAIN
HAD POLIO IMMUNIZATION?	YES	NO	UNCERTAIN
HAD RHEUMATIC FEVER?	YES	NO	UNCERTAIN

FAMILY HISTORY

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

MOTHER_____ SISTER_____

FATHER_____ BROTHER_____

OTHER RELATIVE:_____

REVIEW OF SYSTEMS

ANY MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING:

NO_____ HEAD, IF YES EXPLAIN_____

NO_____ EYES, IF YES EXPLAIN_____

NO_____ EARS, IF YES EXPLAIN_____

NO_____ THYROID, IF YES EXPLAIN_____

NO_____ LUNGS, IF YES EXPLAIN_____

NO_____ HEART, IF YES EXPLAIN_____

NO_____ BLOOD PRESSURE OF VESSELS, IF YES EXPLAIN_____

NO_____ DIGESTIVE SYSTEMS, IF YES EXPLAIN_____

NO_____ LIVER, IF YES EXPLAIN_____

NO_____ MUSCLES-BONES, IF YES EXPLAIN_____

NO_____ REPRODUCTIVE ORGANS, IF YES EXPLAIN_____

NO_____ KIDNEY'S-BLADDERHEAD, IF YES EXPLAIN_____

NO_____ UNSIGHTLY SCARS, IF YES EXPLAIN_____

NO_____ OTHER, IF YES EXPLAIN_____

NO_____ DISEASE AFFECTING IMMUNE SYSTEM, IF YES EXPLAIN_____

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATION(S)? PLEASE LIST

_____

_____

Patient Signature Date