



MEDICAL HISTORY

Name _____
Height _____ Weight _____
Name of Family Physician _____

Drug Sensitivities and /or allergies (list) _____ None (circle if none) _____

Please describe reactions _____

Medications taken with dosage, including herbal medications and supplements:

Multiple horizontal lines for listing medications and dosages.

List all previous surgeries and dates of surgeries: _____

List all other hospitalizations with illnesses and year: _____

Do you take aspirin, ibuprofen or similar medications? [] Yes [] No
Do you smoke? [] Yes [] No How much? _____
Do you consume alcohol? [] Yes [] No How much? _____

Do you now or have you ever had:
Anemia [] Yes [] No Easy Bruising [] Yes [] No
Arthritis [] Yes [] No Chronic Pain Disorders [] Yes [] No
Asthma [] Yes [] No Epilepsy or Seizures [] Yes [] No
Emphysema [] Yes [] No Glaucoma [] Yes [] No
Bladder infections [] Yes [] No High Blood Pressure [] Yes [] No
Kidney Disease [] Yes [] No Heart Disease [] Yes [] No
Chronic Fatigue [] Yes [] No Blood Clots in Legs [] Yes [] No
Diabetes [] Yes [] No Hepatitis [] Yes [] No
Stomach Ulcers [] Yes [] No Immune disorder/ HIV [] Yes [] No
Counseling [] Yes [] No Autoimmune(Lupus, Polyarteritis, etc) [] Yes [] No
Addiction [] Yes [] No

Regarding counseling, please state doctor's name, date, and reason for seeing the doctor.

If necessary will you accept a blood transfusion? [] Yes [] No

Females

Are you currently pregnant? [] Yes [] No Last menstrual date? _____

List date(s) of birth(s) _____

I attest that these statements regarding my medical history are true to the best of my knowledge.

Signature _____ Date _____