



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:

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Easy Bruising	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic Pain Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bladder infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood Clots in Legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Immune disorder/ HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Counseling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Autoimmune(Lupus, Polyarteritis, etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Addiction	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 _____