

## Medical History

Name \_\_\_\_\_

Date \_\_\_\_\_

Do you have a personal physician? Y n

Your current physical health: Good Fair Poor

Physician Name: \_\_\_\_\_

Are you currently under the care of a physician? Y n

Address: \_\_\_\_\_

Please explain: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of last visit \_\_\_\_\_ Are you pregnant? Y n

Please list prescription and/or alternative medications you are taking.

Please list any known allergies


Premedicate y or n Medication- \_\_\_\_\_

Abnormal y n Congenital Heart Defect y n Headaches y n

Liver Disease y n Alcohol Abuse y n Mitral Valve Prolapse y n

Heart Attack y n Low Blood Pressure y n Epilepsy y n

Sinus Problem y n Diabetes Type I II y n Heart Murmur y n

Artificial Joints y n Heart Surgery y n Osteoporosis y n

Stroke y n Drug Abuse y n Pacemaker y n

Hepatitis A B C y n Artificial Valves y n COPD y n

Thyroid Problems y n Seizures y n Herpes y n

Psychiatric Care y n Asthma y n High Blood Pressure y n

Radiation Treatment y n Tuberculosis y n Cancer y n

HIV/AIDS y n Anemia y n Ulcers y n

Chemotherapy y n Kidney Problems y n Blood Disorders y n

Other \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_