MEDICAL HISTORY

Please list your current physician (s):

A) ________________________________ Phone ________________

B) ________________________________ Phone ________________

Circle any condition you now have or have had in the past:

Heart Disease or Attack
Congestive Heart Failure
Angina Pectoris
Congenital Heart Defect
Mitral Valve Prolapse
Heart Surgery
Heart Pacemaker
Artificial Heart Valve
Irregular Heart Beat (Arrhythmia)
High Blood Pressure
High Cholesterol
Stroke
Shortness of Breath
Artificial Joint (Knee, Hip)

COPD
Emphysema
Tuberculosis
Asthma
Allergies or Hives
Diabetes (Type I or II)
Arthritis
Rheumatism
Osteoporosis
Fibromyalgia
Systemic Lupus
Steroid Therapy
Hepatitis (A, B, C, D, E)
Hepatitis B Carrier

Liver Disease
Pancreas Disease
Epilepsy or Seizures
Fainting or Dizzy Spells
Chronic Severe Headaches
HIV
AIDS
Blood Transfusion
Drug or Alcohol Addiction
Glaucoma or Cataracts
Eye Disorders
Cancer or abnormal growth
Radiation Therapy
Chemotherapy

Enlarged Glands or Lymph Nodes
Sickle Cell Disease
Kidney Disease
Bladder Infection
Prostate Disease
Gall Bladder Disease
Unusual Bruising or Bleeding
Anemia or Blood Disorders
Hemophilia
Thyroid Disease
Parathyroid Disease
Ulcers or Colitis
Gastric Reflux
Neurological problems
Anxiety, emotional, or stress-related therapy

Current Medications: ____

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Are you allergic to or have you had an adverse reaction to:

Penicillin	Keflex	Tylenol	Versed	Local anesthetic	Other:
Erythromycin	Codeine	Valium	Iodine	Epinephrine	
Tetracycline	Aspirin	Demerol	Latex gloves	Sulfa Drugs	

Please list any major operations: ____

YES **NO** Do you smoke? How much? ____________ How long? ________________

YES **NO** Are you on a special diet?

YES **NO** Do you have any disease, condition or problem not listed above?

YES **NO** Are you pregnant?

YES **NO** Are you presently breast feeding?

YES **NO** Are you taking birth control pills or hormonal supplements?

Initials_____ Date_______