

Medical History

In Case of Emergency Contact: _____ Relationship to Patient: _____ Phone: _____

Family Physician: _____ Phone: _____

Are You Presently Under a Physician's Care? Yes No _____

If "Yes," for What Condition? _____

Have You Been Hospitalized in the Last 5 Years? Yes No _____

List All Previous SURGERIES: _____

Type _____ Year _____

Type _____ Year _____

Type _____ Year _____

Do You Have Any ALLERGIES? Yes No

Please List/Type _____

Active Medical Problems: _____

Do You or Have You Ever Had Any of the Following:	Anemia?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes?	Prior Blood Transfusion?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stomach or Duodenal Ulcer?	Do You Take Drugs or Any Medications? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Clotting Problems?	Please List: _____	
Abnormal Bleeding or Blood Disorder?	_____	
Hepatitis, Jaundice, or Liver Disease?	_____	
Rheumatic Fever?	_____	
Heart Trouble or Stroke?	Alcohol Use? Yes <input type="checkbox"/> No <input type="checkbox"/>	
High Blood Pressure?	Quantity Per Day _____	
Low Blood Pressure?	Tobacco Use Yes <input type="checkbox"/> No <input type="checkbox"/>	
Chest Pains?	Quantity Per Day _____	
Ankle Swelling?	Have You Taken Other Medications	
Shortness of Breath?	During the Past Year? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Epilepsy or Seizures?	Please List: _____	
Arthritis or Rheumatism?	_____	
Joint Replaced?	Are You a Nervous Person? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Kidney Disease or Infection?	Pertinent Family Medical History:	
Immune Disorder?	_____	
Aids?	_____	

AUTHORIZATION

I authorize such medical treatment as the Physician feels necessary while under his/her scope of care, including the use of pertinent health information to obtain necessary testing or consultation.

Patient Signature: _____ Date: _____