Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

If yes, for what? ____________________

Hospital or Physician's Name ____________________ Phone ____________________

Hospital or Physician's City ____________________ State ____________________

Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) ☐ Yes ☐ No

If yes, please explain ____________________

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Do you have heart problems? ☐ Yes ☐ No

If yes, what are the problems? ____________________

Do you use tobacco? ☐ Yes ☐ No

If yes, please note type (smoking, or oral), and amount/frequency ____________________

Women only: Are you pregnant, or think you may be pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Indicate which of the following you have had, or have at present:

Condition	Yes/No	Condition	Yes/No	Condition	Yes/No
AIDS/HIV	☐ Yes ☐ No	Difficulty Breathing	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Alcohol Addiction	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Nervousness / Anxiety	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Epilepsy / Seizures	☐ Yes ☐ No	Neurologic Disorders	☐ Yes ☐ No
Allergies / Hives	☐ Yes ☐ No	Fainting / Dizzy Spells	☐ Yes ☐ No	Psych Care / Treatment	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fosamax / Bisphosphonates	☐ Yes ☐ No	Rheumatic / Scarlet Fever	☐ Yes ☐ No
Arthritis / Rheumatism	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Shingles / Chicken Pox	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Sickle Cell Disease / Traits	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Bleeding	☐ Yes ☐ No	Heart (Surgery, Disease, Attack)	☐ Yes ☐ No	Snoring / Sleep Apnea	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Stomach Problems / Ulcers	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Hepatitis: A B C (circle)	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Cancer / Chemotherapy	☐ Yes ☐ No	High or Low Blood Pressure	☐ Yes ☐ No	Tuberculosis (TB)	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Hospitalized for Any Reason	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Cold Sores / Herpes	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Venereal Disease / STD	☐ Yes ☐ No
Colitis	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No		
Cortisone Medicine	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No		
Eating Disorder	☐ Yes ☐ No	Lupus	☐ Yes ☐ No		

Please list any serious medical condition(s) you have ever had not listed above: ____________________

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Are you aware of having an allergic (or adverse) reaction to any of the following:

Substance	Yes/No	Substance	Yes/No	Substance	Yes/No
Aspirin	☐ Yes ☐ No	Iodine	☐ Yes ☐ No	Sedatives	☐ Yes ☐ No
Codeine	☐ Yes ☐ No	Jewelry / Metals	☐ Yes ☐ No	Sulfa Drugs	☐ Yes ☐ No
Anesthetics/Novocaine	☐ Yes ☐ No	Latex	☐ Yes ☐ No	Tetracycline	☐ Yes ☐ No
Erythromycin	☐ Yes ☐ No	Penicillin, Other Antibiotics	☐ Yes ☐ No	Other	____________

PATIENT/PARENT SIGNATURE ____________________ **DATE** ____________________

RECERTIFICATION: I certify there have been no changes in my health except as noted below :

CHANGE____________________ DATE__________ SIGNATURE____________________

CHANGE____________________ DATE__________ SIGNATURE____________________

CHANGE____________________ DATE__________ SIGNATURE____________________