Medical History From Date _____

Name _____ Home Phone ( ) _____
Last First Middle

Address _____ Business Phone ( )_____
Number, Street

City _____ State _____ Zip Code _____

Occupation _____ Social Security No. _____

Date of Birth _____/_____/_____ Sex M F Height _____ Weight _____ Single _____ Married _____
mo day yr

Name of Spouse _____ Closest Relative _____ Phone ( ) _____

If you are completing this form for another person, what is your relationship to that person? _____

Referred by _____

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? . . . . . Yes No

2. Has there been any change in your general health within the past year? . . . . . Yes No

3. My last physical examination was on _____

4. Are you now under the care of a physician? . . . . . Yes No

If so, what is the condition being treated? _____

5. The name and address of my physician(s) is _____

_____

_____

6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? . . . . . Yes No

If so, what was the illness or problem? _____

7. Are you taking any medicine(s) including non-prescription medicine? . . . . . Yes No

If so, what medicine(s) are you taking? _____

8. Do you have or have you had any of the following diseases or problems?

a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease . . . . . Yes No

b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) . . . . . Yes No

1. Do you have chest pain upon exertion? . . . . . Yes No

2. Are you ever short of breath after mild exercise or when lying down? . . . . . Yes No

3. Do your ankles swell? . . . . . Yes No

4. Do you have inborn heart defects? . . . . . Yes No

5. Do you have a cardiac pacemaker? . . . . . Yes No

c. Allergy . . . . . Yes No

d. Sinus trouble . . . . . Yes No

e. Asthma or hay fever . . . . . Yes No

f. Fainting spells or seizures . . . . . Yes No

g. Persistent diarrhea or recent weight loss . . . . . Yes No

h. Diabetes. . . . . Yes No

i. Hepatitis, jaundice or liver disease. . . . . Yes No

j. AIDS or HIV infection . . . . . Yes No

k. Thyroid problems . . . . . Yes No

l. Respiratory problems, emphysema, bronchitis, etc. . . . . Yes No

m. Arthritis or painful swollen joints . . . . . Yes No

n. Stomach ulcer or hyperacidity . . . . . Yes No

o. Kidney trouble. . . . . Yes No

p. Tuberculosis . . . . . Yes No

q. Persistent cough or cough that produces blood . . . . . Yes No

r. Persistent swollen glands in neck. . . . . Yes No

s. Low blood pressure . . . . . Yes No

t. Sexually transmitted disease . . . . . Yes No

u. Epilepsy or other neurological disease . . . . . Yes No

v. Problems with mental health . . . . . Yes No

w. Cancer. . . . . Yes No

x. Problems of the immune system . . . . . Yes No