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MEDICAL HISTORY

Name:_____ DOB_____ Sex: M___F___

Height_____ Weight_____

CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING

___ HIGH BLOOD PRESSURE	___STROKE	___CANCER
___ CHEST PAIN	___TUBERCULOSIS	___THYROID DISEASE
___CHRONIC FATIGUE	___ANEMIA	___CONVULSIONS/SEIZURES
___HEART MURMUR	___ASTHMA/WHEEZING	___BRUISE EASILY
___LOSS OF APPETITE	___FAINTING SPELLS	___WEIGHT LOSS
___NOSE BLEEDS	___HAYFEVER/ALLERGIES	___COUGH/BRONCHITIS
___SWOLLEN ANKLES	___ALCOHOLISM	___DIABETES
___SINUS TROUBLE	___LEG PAIN	___ABDOMINAL PAIN(CHRONIC)
___DIFFICULTY SWALLOWING	___NUMBNESS/TINGLING	___LUNG PROBLEMS
___FREQUENT SORE THROAT	___VARICOSE VEINS	___FREQUENT HEADACHES
___HEARTBURN/INDIGESTION	___STOMACH ULCERS	___ARTHRITIS
___BLEEDING DISORDERS	___HEART PROBLEMS	___NAUSEA AND VOMITING
___SHORTNESS OF BREATH	___KIDNEY PROBLEMS	___HOARSENESS/PROLONGED
___DEPRESSION	___DIFFICULTY SLEEPING	___CHANGE IN BOWELS

FOR WOMEN ONLY:

____IRREGULAR PERIODS	___CRAMPING-DISCHARGE	
___NUMBER OF CHILDREN	___NUMBER OF PREGNANCIES	___ARE YOU PREGNANT

FOR MEN ONLY:

___FREQUENT OR PAINFUL URINATION

HOSPITAL ADMISSIONS:

YEAR ILLNESS OR OPERATIONS

_____ _____

_____ _____

ARE YOU ALLERGIC TO ANY MEDICATIONS, PLEASE LIST:

_____

_____

DO YOU SMOKE? _____ **HOW MUCH PER DAY**_____ **FOR HOW MANY YEARS**?_____

DRINK ALCOHOL? NEVER____ OCCASIONAL____ HEAVY_____

HAVE YOU EVER USED RECREATIONAL DRUGS?

_____OCCASIONAL ____HEAVY WHAT KIND?_____

DO YOU USE DRUGS NOW?_____

ARE YOUR PARENTS, BROTHERS/SISTERS STILL LIVING? IF NOT LIST CAUSE OF DEATH:

_____

_____

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