MEDICAL HISTORY

PATIENT _____ DATE OF BIRTH _____

NAME OF PHYSICIAN _____ PHONE _____

CLINIC OR FACILITY NAME _____

WHOM MAY WE NOTIFY IN CASE OF AN EMERGENCY? Name _____ Relationship to you _____

Circle a definite answer for each question:

Yes No ANY CHANGE IN YOUR HEALTH IN THE LAST TWO YEARS?

Yes No ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?
IF YES, DESCRIBE YOUR TREATMENT _____

Yes No HAVE YOU HAD ANY MEDICAL TREATMENT OR PHYSICIAN VISIT OF ANY KIND IN THE LAST TWO YEARS? IF YES, DESCRIBE _____

Yes No HAVE YOU EVER HAD ANY SURGICAL OPERATION OF ANY KIND? IF YES, DESCRIBE _____

Yes No WERE YOU TRANSFUSED AT THAT TIME?

Yes No HAVE YOU BEEN ADVISED BY A PHYSICIAN OF THE NEED FOR ANY TYPE OF SURGERY OR TREATMENT? FOR WHAT? _____

DO YOU HAVE, HAVE YOU HAD, OR BEEN TREATED FOR, ANY OF THE FOLLOWING?:

Yes No ARTHRITIS
Yes No RHEUMATIC FEVER
Yes No HEART PROBLEMS
Yes No HIGH BLOOD PRESSURE
Yes No LOW BLOOD PRESSURE
Yes No ANEMIA, SICKLE CELL DISEASE
Yes No EPILEPSY, SEIZURES
Yes No FAINTING SPELLS
Yes No DIABETES
Yes No HEPATITIS
Yes No ULCERS
Yes No KIDNEY DISORDER
Yes No TUBERCULOSIS
Yes No ENZYME DEFICIENCY
Yes No HIV
Yes No HYDROCEPHALUS
Yes No ANOREXIA, BULIMIA
Yes No CHEMICAL DEPENDENCY
Yes No CHRONIC DIARRHEA

Yes No THYROID CONDITION
Yes No VENEREAL DISEASE HERPES II
Yes No ACQUIRED IMMUNE DEFICIENCY SYNDROME
Yes No PACEMAKER TYPE
Yes No HIP OR JOINT REPLACEMENT
Yes Nka ALLERGY
Yes No RADIATION OR CHEMICAL THERAPY
Yes No EAR INFECTIONS
Yes No CHRONIC SINUS
Yes No ASTHMA
Yes No HEMOPHILIA, BLEEDING OR BLOOD DISORDER
Yes No AIDS RELATED COMPLEX
Yes No HEART MURMUR
Yes No HYPOTHERMIA
Yes No MITRAL VALVE PROLAPSE

Yes Nka HAVE YOU EVER HAD AN ALLERGIC REACTION OR BEEN TOLD NOT TO TAKE ANY MEDICATION? IF YES, DESCRIBE _____

Yes No ARE YOU CURRENTLY TAKING ANY PRESCRIPTION DRUGS OF ANY KIND (Example: Birth Control, Hormone, Diet)? IF YES, WHAT? _____

Yes No ARE YOU CURRENTLY TAKING ANY NONPRESCRIPTION DRUGS OF ANY KIND (Example: Aspirin, Cough Syrup, Nasal Spray, Recreational Drug Use, Sugar, Caffeine)?
IF YES, WHAT? _____

Yes No ARE YOU PREGNANT? ANTICIPATED DELIVERY DATE _____

Yes No DO YOU USE ANY TOBACCO PRODUCT? DAILY INTAKE _____

Yes No DO YOU WEAR CONTACT LENSES?

BLOOD PRESSURE: S_____/D_____/_____

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE _____
Patient or Guardian of Minor

MMH2S (6/95)