



MEDICAL HISTORY

Name: _____ Date: _____

Height: _____ Weight: _____ Race: _____ Age: _____ Sex: _____

Please take a few moments to answer the following questions as completely as possible. All information is strictly confidential.

1. Do you have a history of any of the following conditions?

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure? |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease (i.e., murmur, pacemaker)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung disease (i.e., asthma, tuberculosis)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes or low blood sugar? |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach problems (i.e., ulcers, gastritis)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease (i.e., hepatitis)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia or bleeding disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle, bone, or joint disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin disorder (i.e., acne, rosacea, cancer)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Immune system disorder (i.e., HIV, AIDS, ARC)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder or stroke? |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric or emotional disorder (i.e., depression, anxiety)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Other medical or health problems? |

If you answered *Yes* to any of the questions above, please explain: _____

2. Please list all medications (including over-the-counter medicine) you are presently taking:

3. Are you allergic to any medication? Yes No If *Yes*, please list: _____

4. Have you ever been hospitalized? Yes No If *Yes*, for what reason? _____

5. Please list all prior surgery (including any cosmetic procedures) with dates: _____

6. Do you drink alcohol? Yes No If Yes, how many drinks per week? _____

7. Do you smoke? Yes No If Yes, how many packs per day? _____

8. Do you use recreational drugs (i.e., marijuana, cocaine, or other drugs)? Yes No

9. Have you ever had a blood transfusion? Yes No

10. Is there any possibility that you might be pregnant? Yes No

Patient Signature

Date

~~~~~ PLEASE DO NOT WRITE BELOW THIS LINE ~~~~~

Examiner's Comments: \_\_\_\_\_

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Signature

\_\_\_\_\_  
Date