MEDICAL HISTORY

NAME:_____
LAST FIRST MIDDLE

Have you been ill recently? Y / N

Have you been hospitalized in the last 3 years? Y / N

Are you under the care of a physician for any condition at this time? Y / N

Do you or have you ever had any of the following?

Diabetes	Y / N	Jaundice	Y / N
Rheumatic Fever	Y / N	Hepatitis	Y / N
Heart disease/attack	Y / N	Epilepsy	Y / N
High Blood Pressure	Y / N	Tuberculosis	Y / N
Anemia	Y / N	Asthma	Y / N
Stroke	Y / N	Venereal Disease	Y / N
HIV	Y / N		

Are you taking any medicines or drugs now? Y / N

1._____
2._____
3._____

Are you allergic to Penicillin? Y / N

-If yes, what reaction did you have?

_____

Are you allergic to any other medicines? Y / N

1._____
2._____

Do you have any circulatory problems? Y / N

-bleeding or clotting problems? Y / N

-sickle cell anemia? Y / N

Have you ever had surgery for a tumor or growth? Y / N

Are you pregnant? Y / N

Name and Address and phone number of your physician:

_____

_____

_____
Signature of Patient Date