MEDICAL HISTORY

CIRCLE

1. Have you ever been a patient in the hospital during the past two years? YES NO
2. Have you been under the care of a medical doctor during the past two years? YES NO
3. Are you taking any pills, medications or drugs **(including aspirin/ASA)** or other non-prescription drugs? List: _____ YES NO
   _____
4. When was your last physical examination? _____
5. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any other drugs or medications? YES NO
6. Have you ever had any excessive bleeding requiring special treatment? YES NO
7. Do you smoke? Current: YES NO Previous: YES NO Never: YES NO
   If so, how much? _____
8. Do you use recreational drugs? Current: YES NO Previous: YES NO Never: YES NO
   If so, how often? _____ What kind? _____
9. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	HIV Positive
Heart Disease or Attack	Persistent Cough	Hepatitis Type A (Infectious)
Ulcers	Hay Fever	B (serum), C or D
Angina Pectoris	Tuberculosis (TB)	Liver Disease
High Blood Pressure	Asthma	Yellow Jaundice
Low Blood Pressure	AIDS	Blood Transfusion
Rheumatic Fever	Pacemaker	Hemophilia
Rheumatic Heart Disease	Sinus Trouble	Venereal Disease (Syphilis, Gonorrhea)
Heart Murmur	Allergies or Hives	Drug Addiction
Congenital Heart Defect	Diabetes	Cold Sores
Scarlet Fever	Thyroid Disease	Genital Herpes
Artificial Heart Valve	X-Ray or Radiation Therapy	Epilepsy or Seizures
Heart Pace Maker	Chemotherapy, (Cancer, Leukemia)	Fainting or Dizzy Spells
Heart Surgery	Arthritis	Nervousness
Artificial Joint	Rheumatism	Psychiatric Treatment
Anemia	Cortisone Medicine (Steroids)	Sickle Cell Disease
Stroke	Glaucoma	Bruise Easily
Pain in Jaw Joints		

10. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? YES NO
11. Do your ankles swell during the day? YES NO
12. Do you use more than 2 pillows to sleep? YES NO
13. Have you gained more than 10 pounds in the past year? YES NO
14. Do you ever wake up from sleep short of breath? YES NO
15. Are you on a special diet? YES NO
16. Has your medical doctor ever said you have cancer or a tumor? YES NO
17. Do you have any disease, condition, or problem not listed? YES NO
18. Are you under abnormal stress? (for example, marital, business or social)? YES NO
19. WOMEN: Are you pregnant now? YES NO
    Are you taking oral contraceptives? (Birth Control Pills) YES NO
    Do you anticipate becoming pregnant? YES NO
    Have you reached menopause? YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

_____ _____

Date Signature of Patient, Parent or Guardian