MEDICAL HISTORY

NAME OF PHYSICIAN	IF SPECIALIST, WHAT TYPE?	PHYSICIAN PHONE NO.	DATE OF LAST VISIT TO PHYSICIAN
ADDRESS			PHARMACY @ PHONE NO.

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING? PLEASE CHECK ANY THAT APPLY.

Heart Problems ❑
- Chest pain ❑
- Shortness of breath ❑
- Blood pressure problem ❑
- Heart murmur ❑
- Heart valve problem ❑
- Taking heart medication ❑
- Rheumatic fever ❑
- Pacemaker ❑
- Artificial heart valve ❑

Blood Problems ❑
- Easy bruising ❑
- Frequent nose bleeds ❑
- Abnormal bleeding ❑
- Blood disease (anemia) ❑

Allergy Problems ❑
- Hay fever ❑
- Sinus problems ❑
- Skin rashes ❑
- Taking allergy medication ❑
- Asthma ❑

Intestinal Problems ❑
- Ulcers ❑
- Weight gain or loss ❑
- Special diet ❑
- Constipation ❑

Bone or Joint Problems ❑
- Arthritis ❑
- Back or neck pain ❑
- Joint replacement (eg., total hip) ❑
- Any prosthetic parts ❑

Fainting Spells, Seisures, or Epilepsy ❑

Psychiatric treatment ❑

Diabetes ❑
- Urinate more than 6 times a day ❑
- Thirsty or mouth is dry much of the time ❑
- Family history of diabetes ❑

Tuberculosis or other respiratory disease ❑

Cancer/Tumor ❑
- Radiation treatment ❑

Do You Drink? ❑
- If so, how much? ❑

Do You Smoke? ❑
- If so, how much? ❑
- Using smokeless tobacco? ❑

Herpes ❑
Venereal Disease ❑
HIV-Positive/AIDS ❑
Hepatitis ❑
Glaucoma ❑
Do You Wear Contact Lenses? ❑

Hospitalization for illness or surgery ❑

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING?

Local anesthetics ("Novocaine") ❑
Penicillin or other antibiotics ❑
Sulfa drugs ❑
Barbiturates, sedatives, or sleeping pills ❑
Aspirin ❑
Codeine ❑
Other ❑

ARE YOU:

Presently being treated for any illness? YES ❑ NO ❑
Aware of a change in your general health in the past year? YES ❑ NO ❑
Are there any other conditions we should know about? YES ❑ NO ❑

DURING THE PAST 12 MONTHS HAVE YOU TAKEN ANY OF THE FOLLOWING?

Antibiotics or sulfa drugs ❑
Anticoagulants (eg., Coumadin) ❑
High blood pressure medicine ❑
Tranquilizers ❑
Insulin, Orinase, or similar drug ❑
Aspirin ❑
Digitalis or drugs for heart trouble ❑
Nitroglycerin ❑
Cortisone (steroids) ❑
Other ❑
Other ❑

WOMEN

Are you taking contraceptives or other hormones? ❑
Are you pregnant? ❑
If so, expected delivery date? _____

I have completed the above health history and to the best of my knowledge have answered all questions correctly.

Signature _____ Date _____