Medical History

Patient Name_____ **Date of Birth**_____

SS/HIC/Patient ID#_____

	Yes	No
AIDS/HIV Positive	○	●
Allergies	○	●
Anemia	○	●
Angina	○	●
Anxiety	○	●
Arthritis, Rheumatism	○	●
Artificial Heart Valves	○	●
Artificial Joints	○	●
Asthma or Hay Fever	○	●
Back Problems	○	●
Bleeding Abnormally,with extractions or surgery	○	●
Blood Disease	○	●
Blood Transfusion	○	●
Cancer Therapy	○	●
Chemical Dependency	○	●
Chemotherapy	○	●
Circulatory Problems	○	●
Claustrophobia	○	●
Congenital Heart Lesions	○	●
Contact Lenses	○	●
COPD	○	●
Cortisone Treatments	○	●
Cough, persistent or Bloody	○	●

	Yes	No
Depression	○	●
Diabetes	○	●
Emphysema	○	●
Endocarditis	○	●
Epilepsy	○	●
Fanting or dizziness	○	●
Fibromyalgia	○	●
Glaucoma	○	●
Headaches	○	●
Heart Attack	○	●
Heart Murmur	○	●
Heart Disease	○	●
Hemophilia	○	●
Hepatitis A	○	●
Hepatitis B	○	●
Hepatitis C	○	●
Herpes	○	●
High Blood Pressure	○	●
Jaundice	○	●
Jaw Pain	○	●
Kidney Disease	○	●
Leukemia	○	●
Liver Disease	○	●
Low Blood Preasure	○	●

	Yes	No
Measles or Mumps	○	●
Mitral Valve Prolapse	○	●
Neurological Problems	○	●
Pacemaker	○	●
Psychiatric Care	○	●
Radiation Treatment	○	●
Respiratory Disease	○	●
Rheumatic Fever	○	●
Scarlet Fever	○	●
Shortness of Breath	○	●
Seizures	○	●
Sinus Trouble	○	●
Skin Rash	○	●
Special Diet	○	●
Stroke	○	●
Swollen Feet or Ankles	○	●
Swollen Neck Glands	○	●
Thyroid Problems	○	●
Tonsillitis	○	●
Tuberculosis	○	●
Tumor or growth on head or neck	○	●
Ulcer	○	●
Venereal Disease	○	●
Weight Loss, Unexplained	○	●