MEDICAL History Update

YOUR NAME: ___________________________________________ Phone #: ________________________

Physician’s Name: _____________________________________ Phone #: ________________________ When was your last visit to your physician? __________

When was your last complete physical? ________________

Please tell us if you have had any of the following by checking the appropriate box:

☐ Bacterial Endocarditis  ☐ Hemophilia  ☐ Any Artificial Replacement
☐ Heart Murmur  ☐ Blood Disease  ☐ Artificial Knee, Hip, Joint, Pins, Plate
☐ Irregular Heart Beat  ☐ Sickle Cell Anemia  ☐ Rheumatism / Arthritis
☐ High Blood Pressure  ☐ Anemia / Blood Problems  ☐ Neurological Problems
☐ Low Blood Pressure  ☐ Excessive Bleeding  ☐ Epilepsy / Seizures
☐ Rheumatic Heart Fever  ☐ Asthma  ☐ Psychiatric Problems
☐ Rheumatic Heart Disease  ☐ Respiratory Disease  ☐ Emotional Problems
☐ Artificial Heart Valves  ☐ Shortness of Breath  ☐ Alcoholism
☐ Congenital Heart Lesion  ☐ Hay Fever  ☐ Chemical Dependency
☐ Mitral Valve Prolapse  ☐ Sinus Problems  ☐ Drug Addiction
☐ Heart Attack _____ year  ☐ Tuberculosis  ☐ Malignancies
☐ Angina/ Chest Pain  ☐ Eye Disorders / Glaucoma  ☐ Cancers, Tumors, Growths
☐ Heart Pacemaker  ☐ AIDS  ☐ Radiation Treatments
☐ Heart Surgery  ☐ Immunosuppressive Disorders / ARC  ☐ Venereal Disease
☐ Congestive Heart Failure  ☐ Chemotherapeutic Agents  ☐ Ulcer / Colitis

Please list any ALLERGIES to Drugs, Medications or Anesthetics:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please list any other MEDICAL CONDITIONS not mentioned above:
________________________________________________________________________

Please list all DRUGS/MEDICATIONS that you currently take:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

________________________________________________________________________

Patient Signature ________________________ Date __________________________