

Medical History Update

YOUR NAME: _____

Today's Date: _____

Physician's Name: _____

Physician's 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(es):

- | | | | |
|----------------------------------------------------|---------------------------------------------------|-----------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Bacterial Endocarditis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Any artificial replacement | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Blood Disease | Artificial Knee, Hip, Joint | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Sickle Cell Anemia | Pins, Plate | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia / Blood Problems | <input type="checkbox"/> Rheumatism / Arthritis | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatic Heart Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Heart Valve(s) | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Ulcer / Colitis |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Heart Attack ____ Year | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Eye Disorders / Glaucoma | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Pregnant ____ Months |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> AIDS | <input type="checkbox"/> Cancers, Tumors, Growths | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Immunosuppressive | <input type="checkbox"/> Radiation Treatments | |
| <input type="checkbox"/> Congestive Heart Failure | Disorders / ARC | | |

Please list any ALLERGIES to Drugs, Medications or Anesthetics:

Please list any other MEDICAL CONDITIONS not mentioned above:

Please list all DRUGS/MEDICATIONS you currently take:

Patient Signature

Date