

MEDICAL HISTORY

Date of Birth _____ Age _____

Date of Last Health Care Exam _____ Reason for _____

Have you been hospitalized in the last 5 years _____ if so for what reason _____

Do You Have or Have You Ever Had;

Anemia	_____	Heart Murmur	_____
Diabetes	_____	Heart Condition (Stroke)	_____
Epilepsy	_____	Abnormal Blood Pressure	_____
Hepatitis	_____	High _____ Low _____	
Rheumatic Fever	_____	Malignancies (cancer)	_____
Arthritis	_____	Kidney or Liver Disease	_____

Any Allergies _____

If allergies to medications or drugs, please list _____

Please list any medications you may currently be taking (please include over the counter drugs)

Please list reason for any medications that you may be taking _____

Please list any physical conditions _____

Are you currently receiving healthcare, if so please list reason _____

Please list any family history that may be pertinent:

As the undersigned below, I am a legally responsible party, I certify that all the information that I have supplied is complete and correct. And I assume full financial responsibility for any and all professional services supplied and/or rendered.

Name Date

Witness Date

