Medical Information Form

(1) MEDICAL HISTORY

Have you ever had any of the following ?

- Heart Disease ☐
- Heart Murmur ☐
- Rheumatic Fever ☐
- Asthma ☐
- Pneumonia ☐
- High Blood Pressure ☐
- Stroke ☐
- Blood Clot in Vein ☐
- Anemia ☐
- Connective Tissue Disease ☐
- Anemia ☐
- Sickle Cell Disease ☐
- Blood Transfusion ☐
- High Cholesterol ☐
- Diabetes ☐
- Cancer ☐
- What Type? ____________________
- Migraines ☐
- Congenital Disease ☐
- Seizures ☐
- Epilepsy ☐
- Liver Disease ☐
- Hepatitis ☐
- Mononucleosis ☐
- Gall Bladder Disease ☐
- Kidney Problems ☐
- Mood Disorders ☐
- STD's ☐
- Rubella ☐
- Genetic Condition ☐
- Overwight ☐
- Underweight ☐
- Drug Abuse ☐
- Other ____________________

Do you experience any of the following regularly?

- Chest Pain ☐
- Headaches ☐
- Shortness of Breath ☐
- Sensory Difficulties ☐
- Vision Problems ☐
- Pain ☐
- Dizziness ☐

Have you been admitted to the hospital?

Date of Admission ____________________ Hospital Name ____________________

Reason ____________________

(2) FAMILY HISTORY

Do any of the following conditions run in your family?

- Stroke ☐
- Heart Attack ☐
- High Cholesterol ☐
- High Blood Pressure ☐
- Cancer ☐
- What Type ? ____________________
- Diabetes ☐
- Genetic Condition ☐
- Breast Cancer ☐

(3) Social History

Do you Smoke? Yes ☐ No ☐

How many times per day? ____________________

Do you drink alcohol? Yes ☐ No ☐

How many times per week? ____________________

Use illegal drugs? Yes ☐ No ☐

If Yes, Which ones? ____________________

(4) MEDICATION / ALLERGIES

Please list any Medication that are being taken.

Medication/ Dosage ____________________

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Please list any Allergies.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

This information is correct and up-to-date to the best of my knowledge Sign ____________________ Date ____________