PATIENT MEDICAL HISTORY

Medical Doctor's Name _____ Phone _____
Address _____

	Yes	No
Have you been seen by your medical doctor during the past year?	____	____
Have you ever been **hospitalized?**	____	____
If so, for what? _____		
Have you ever had **surgery?**	____	____
If so, please describe _____		
Have you had any serious accident involving **head injuries?**	____	____
Do you smoke?	____	____
Do you use smokeless tobacco?	____	____
Are you **allergic** to any drug or medications?	____	____
If so, please list _____		

Have you ever had any of the following?

Yes	No		Yes	No	
____	____	Heart Murmur	____	____	Joint Replacement
____	____	Mitral Valve Prolapse	____	____	Stroke
____	____	Heart Surgery	____	____	Diabetes
____	____	Heart Attack	____	____	Tumor or Growth
____	____	Angina	____	____	Hepatitis
____	____	Pacemaker	____	____	Kidney Disease
____	____	Artificial Heart Valve	____	____	Excessive Bleeding
____	____	Rheumatic Fever	____	____	Blood Transfusion
____	____	High Blood Pressure	____	____	Anemia
____	____	Low Blood Pressure	____	____	Fainting spells
____	____	Arrhythmias	____	____	Convulsions
____	____	Bacterial Endocarditis	____	____	Seizures
____	____	Other heart problems	____	____	Venereal Disease
____	____	Valve Replacement	____	____	HIV
____	____	Tuberculosis	____	____	AIDS
____	____	Emphysema	____	____	Chemical Dependency
____	____	Asthma	____	____	Chemotherapy
____	____	Shortness of Breath	____	____	Radiation Treatment

Are you now:

____	____	In good health
____	____	Pregnant
____	____	On a prescribed diet

Are you now taking:

____	____	Beta blockers
____	____	Anticoagulants
____	____	Immunosuppressants
____	____	Other medication

Please indicate any other information about your medical history which you feel may be important _____