

## 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:

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Please list any other MEDICAL CONDITIONS not mentioned above:

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Please list all DRUGS/MEDICATIONS you currently take:

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**Patient Signature**

\_\_\_\_\_  
**Date**