MEDICAL HISTORY

NO		YES	COMMENTS
☐	Care of physician? (who, why)	☐	
☐	Serious illness?	☐	
☐	Cancer, tumor malignancy? (Type, When, Where, treatment)	☐	
☐	AIDS/HIV Positive	☐	
☐	Serious injuries?	☐	
☐	Hospital admissions?	☐	
☐	Operations? (what, when, where)	☐	
☐	Local Anesthetic (personal or family complications)	☐	
☐	General Anesthetic (personal or family complications)	☐	
☐	Transfusions? (why, when)	☐	
☐	Pregnancies? (past, present)	☐	
☐	Allergies? (food, drugs, other)	☐	
☐	Present medications (kinds, dosage)	☐	
☐	Illicit drugs	☐	
☐	Alcohol	☐	
☐	Tobacco	☐	
☐	Premedicate	☐	

NO		YES	COMMENTS
	CARDIOVASCULAR:		
☐	Angina pectoris	☐	
☐	Myocardial infarction	☐	
☐	Congenital heart defect	☐	
☐	Rheumatic fever	☐	
☐	Rheumatic heart disease	☐	
☐	Murmurs	☐	
☐	Hypertension	☐	
☐	Stroke Other	☐	
☐	Mitrovalve prolapse	☐	
	RESPIRATORY:		
☐	Tuberculosis	☐	
☐	Emphysema	☐	
☐	Asthma	☐	
☐	Shortness of breath	☐	
☐	Dyspnea on exertion	☐	
☐	Orthopnea	☐	
☐	Edema	☐	
☐	Other	☐	
	MUSCULOSKELETAL:		
☐	Arthritis	☐	
☐	Bone Disorders	☐	
☐	Fractures	☐	
☐	Muscular Disorders	☐	
☐	Others:	☐	
	GENITOURINARY:		
☐	Kidney infections	☐	
☐	Venereal disease	☐	
☐	Other:	☐	

NO		YES	COMMENTS
	ENDOCRINE:		
☐	Diabetes	☐	
☐	Adrenal disorders	☐	
☐	Thyroid disorders	☐	
☐	Parathyroid disorders	☐	
☐	Steroids	☐	
☐	Other:	☐	
	HEMATOPOIETIC:		
☐	Anemia	☐	
☐	Bleeding disorders	☐	
☐	Anticoagulants	☐	
☐	Leukemia	☐	
☐	Other:	☐	
	NEUROLOGIC:		
☐	Paralysis	☐	
☐	Epilepsy	☐	
☐	Convulsions	☐	
☐	Psychiatric treatment	☐	
☐	Faints/Spells	☐	
☐	Tranquilizers	☐	
☐	Other:	☐	
	GASTROINTESTINAL/LIVER:		
☐	Ulcers	☐	
☐	Bleeding	☐	
☐	Hepatitis	☐	
☐	Jaundice	☐	
☐	Cirrhosis	☐	
☐	Other:	☐	

LAST PHYSICAL EXAMINATION: _____ DATE: _____ WHY: _____

Patient Signature: _____ Date _____