

History Form

Name: _____ **Date:** _____

Date of Birth: _____

Allergies: Medications or Latex _____

Medical History: Have you had or do you have any of the following:

High Blood Pressure	Y	N	Kidney/Bladder	Y	N
Heart Attack	Y	N	Thyroid	Y	N
Angina/Chest Pain	Y	N	Diabetes	Y	N
Heart Murmur	Y	N	Communicable Disease	Y	N
Rheumatic Fever	Y	N	Epilepsy	Y	N
Heart Valve Problems	Y	N	Stroke	Y	N
Irregular Heart Beat	Y	N	Lyme Disease	Y	N
Circulation Problems	Y	N	Back Problems	Y	N
Pace Maker	Y	N	Depression	Y	N
Internal Defibrillator	Y	N	Anxiety	Y	N
Asthma	Y	N	Hepatitis	Y	N
Hiatal Hernia	Y	N	Stomach	Y	N
AIDS/HIV	Y	N	Other: _____		

Please list all previous surgeries:

Family History:	Major Illnesses	Age	If Deceased
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____

Tobacco Use: Y N Pack per day _____ How long _____ Quit Y N
Alcohol Use: Y N How much _____
Drug Abuse: Y N _____

Please List Current Medications:

