

# PERSONAL MEDICAL HISTORY

NAME: \_\_\_\_\_ AGE \_\_\_\_\_ Date of last Physical Exam \_\_\_\_\_

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

**Today's Date:** \_\_\_\_\_

- |            |           |   |
|------------|-----------|---|
| <b>YES</b> | <b>NO</b> |   |
| _____      | _____     | 1. High Cholesterol or Blood fat  |
| _____      | _____     | 2. Heart problems   |
| _____      | _____     | 3. High blood pressure (hypertension)   |
| _____      | _____     | 4. Diabetes   |
| _____      | _____     | 5. Circulation problems   |
| _____      | _____     | 6. Radiation treatments   |
| _____      | _____     | 7. Excessive bleeding   |
| _____      | _____     | 8. Bruise easily  |
| _____      | _____     | 9. <b>Allergies to anesthetics</b>  |
| _____      | _____     | 10. <b>Allergies to <u>medications</u> or <u>food</u>:</b><br>if YES, list: _____ |
| _____      | _____     | 11. Anemia  |
| _____      | _____     | 12. Arthritis   |
| _____      | _____     | 13. Lung problems   |
| _____      | _____     | 14. Asthma  |
| _____      | _____     | 15. Alcohol problems  |
| _____      | _____     | 16. Swallowing problems   |
| _____      | _____     | 17. Hepatitis or jaundice   |
| _____      | _____     | 18. HIV- positive or AIDS   |
| _____      | _____     | 19. Malignancies (cancer)   |
| _____      | _____     | 20. Kidney stones   |
| _____      | _____     | 21. Blood in urine  |
| _____      | _____     | 22. Sugar or albumin in urine   |

- |            |           |   |
|------------|-----------|---|
| <b>YES</b> | <b>NO</b> |   |
| _____      | _____     | 23. Difficult w/ vision   |
| _____      | _____     | 24. Glaucoma  |
| _____      | _____     | 25. Sinus problems  |
| _____      | _____     | 26. Stroke  |
| _____      | _____     | 27. Epilepsy or fits (seizures)   |
| _____      | _____     | 28. Nervous problems  |
| _____      | _____     | 29. Psychiatric treatment/disorder  |
| _____      | _____     | 30. Tuberculosis  |
| _____      | _____     | 31. Stomach trouble   |
| _____      | _____     | 32. Headaches   |
| _____      | _____     | 33. Eyeglasses  |
| _____      | _____     | 34. Contact lenses  |
| _____      | _____     | 35. Hearing aides   |
| _____      | _____     | 36. Dentures  |
| _____      | _____     | 37. Backaches   |
| _____      | _____     | 38. Menstrual problems  |
| _____      | _____     | 39. Are you or could you be pregnant?                                     |
| _____      | _____     | 40. Do you smoke or chew?<br>If yes, how much? _____                      |
| _____      | _____     | 41. Did you previously smoke/chew?<br>If yes when did you quit? _____     |
| _____      | _____     | 42. Would you agree to a blood transfusion in<br>a life threatening case? |
| _____      | _____     | 43. Do you take Anticoagulants?   |

**HAVE YOU HAD**    YES    NO (In the past 5 years)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

- |                      |                |              |                    |                     |  |
|----------------------|----------------|--------------|--------------------|---------------------|--|
| 1. Chest X-ray       | _____          | _____        | When? _____        | Why? _____          | Other X-rays in the last 5 years _____ |
| 2. EKG               | _____          | _____        | When? _____        | Why? _____          |  |
| 3. CAT scan          | _____          | _____        | When? _____        | Why? _____          |  |
| 4. Ultra sound       | _____          | _____        | When? _____        | Why? _____          |  |
| 5. Transfusion       | _____          | _____        | When? _____        | Why? _____          |  |
| 6. Fracture          | _____          | _____        | What? _____        | When? _____         |  |
| 7. Family History of | Diabetes _____ | Cancer _____ | Tuberculosis _____ | Heart Disease _____ | Strokes _____                          |

**HOSPITALIZATIONS** List all surgeries, procedures (including dental), illnesses and treatments (i.e., chemotherapy):

DATE	SURGERY, PROCEDURE, ILLNESS OR TREATMENT

**MEDICATIONS** List all medications currently being taken or used (include birth control, vitamins, topicals, heart, etc.):

Within the last year I have used (check all that apply): Retin-A/Renova _____ Accutane _____

**Family History**

	Living	Dead	If deceased, cause		Age	Living	Deceased	If deceased, cause
Father	_____	_____	_____	Children	_____	_____	_____	_____
Mother	_____	_____	_____		_____	_____	_____	_____
Brother	_____	_____	_____		_____	_____	_____	_____
Sister	_____	_____	_____		_____	_____	_____	_____