# Medical History

| | |
|---|---|
| **Family Physician:** | **Specialty:** |
| **Address:** | **Phone:** |
| **In case of emergency, notify:** | **Name:** |
| **Relationship:** | **Phone #:** |

## Please Circle "Y" for yes or "N" for no:

1. Y N Medical Problem
2. Y N Heart Trouble
3. Y N Heart Murmur
4. Y N Rheumatic Fever
5. Y N High Blood Pressure
6. Y N Low Blood Pressure
7. Y N Pain in Chest
8. Y N Shortness of Breath
9. Y N Swollen Ankles
10. Y N Anemia
11. Y N Headaches
12. Y N Supervised Diet
13. Y N Alcohol Dependency
14. Y N Stroke
15. Y N Diabetes
16. Y N Fainting/Dizziness
17. Y N Insomnia
18. Y N Nervous Disorder
19. Y N Asthma/Hay fever
20. Y N Tuberculosis
21. Y N Hepatitis
22. Y N Arthritis
23. Y N Tumor/Cancer
24. Y N Excessive Bleeding
25. Y N Prosthetic Replacement
26. Y N Tobacco Dependency
27. Y N Major Operation
28. Y N Serious Accident
29. Y N HIV+
30. Y N Change in weight
31. Y N Easily Fatigued
32. Y N Ulcers
33. Y N Cough
34. Y N Communicable Disease
35. Y N Liver Problems
36. Y N Psychiatric Treatment
37. Y N Kidney Problem
38. Y N Drug Dependency
39. Y N Medication Allergies

**Women:**

**1.-)** **Y** **N** **Pregnant? _____ Months**

**2.-)** **Y** **N** **Miscarriage _____**

**3.-)** **Y** **N** **Menopause/Supportive Medication _____**

| **If yes, please explain (By number):** |
|---|
| |
| |
| |

| **List all medication (include aspirin, sleeping medication, sedative):** | |
|---|---|
| **Taking:** | **For:** |
| **Taking:** | **For:** |
| **Taking:** | **For:** |

**Do you need to be pre-medicated?**

**Y N - Medication: _____ For: _____**

**Are there any medical concerns or life style situations that you would like to discuss?**

**Date: _____ Signature: _____**