MEDICAL HISTORY

Patient Name:
____ **Date:**______________________________

Personal History-- Have YOU ever had:

Impaired Vision	□ Yes	□ No	Heart Attack	□ Yes	□ No
Impaired Hearing	□ Yes	□ No	Irregular Heart Rhythm	□ Yes	□ No
Concussion/Head Injury	□ Yes	□ No	Congestive Heart Failure	□ Yes	□ No
Black Out Spells	□ Yes	□ No	Diabetes	□ Yes	□ No
Seizures	□ Yes	□ No	High Blood Pressure	□ Yes	□ No
Stroke/TIA's	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No
Asthma	□ Yes	□ No	Arthritis	□ Yes	□ No
Pneumonia	□ Yes	□ No	Bleeding Tendencies	□ Yes	□ No
Emphysema	□ Yes	□ No	Kidney Disease	□ Yes	□ No
Respiratory/Lung Problems	□ Yes	□ No	Cancer of any Kind	□ Yes	□ No
Prostate Disease	□ Yes	□ No	Drug/Alcohol Abuse	□ Yes	□ No
Impotence	□ Yes	□ No	Mental Illness	□ Yes	□ No
High Cholesterol	□ Yes	□ No	Tuberculosis	□ Yes	□ No

Do you experience heaviness, fatigue or cramping in your legs when walking? □ Yes □ No

Have you been living with anyone in the past 2 years who has been diagnosed with TB? □ Yes □ No

Have you had a persistent cough and fever for more than 2 weeks? □ Yes □ No

Have you had a persistent cough and night sweats for more than 2 weeks? □ Yes □ No

Have you had a persistent cough and loss of appetite for more than 2 weeks? □ Yes □ No

Have you been coughing up or spitting up bloody sputum (saliva)? □ Yes □ No

Have you ever been on steroids (such as cortisone)? □ Yes □ No

Do you take Aspirin (not Tylenol) on a regular basis? □ Yes □ No

Do you smoke? □ Yes □ No

How many packs per day? ______ How many years? ______

Did you ever smoke? □ Yes □ No

How many packs per day? ______ When did you quit? ______

Do you drink alcohol? □ Yes □ No

How many drinks per day? ______

Family History-- Has anyone in your immediate family had:

Coronary Artery Disease □ Yes □ No

Aneurysm □ Yes □ No

-PLEASE CONTINUE ON NEXT PAGE-

Patient Name: ____________________________________

Operations and/or Hospitalizations (Reason and Date): ____

List any allergies (include medications, foods, animals, etc.) **and the reaction you have** (hives, shortness of breath, etc.):

List all medications with dosage and frequency (include prescriptions medications, vitamins, and aspirin):

Name of Medication	Dosage (mg./mcg.)	Frequency (How many times per day?)