

PATIENT MEDICAL HISTORY

Patient Name _____

In Case Of Emergency Contact: _____

Relationship _____ **Phone Number** _____

PRESENT MEDICAL CONDITION

Medication

Allergies _____

Current Illnesses Being Treated For _____

Current Medications(including vitamins)

Do You Smoke? (if yes, how much?) _____

Do you drink or use illegal drugs? (if yes how often) _____

Are you or do you think that you may be pregnant? _____

Date of last mammogram: _____

List all previous operations _____

In the event of an emergency do you object to receiving a “screened” blood transfusion? _____

Have you ever had any of the following conditions or diseases?

Heart Disease	_____	Rheumatic Fever	_____
Prolapsed Mitral Valve	_____	High Blood Pressure	_____
Emphysema or Asthma	_____	Tuberculosis	_____
Chronic Bronchitis	_____	Hepatitis	_____
Kidney Disease	_____	Ulcer	_____
Bowel Disease	_____	Bleeding Disorder	_____
Circulation Problems	_____	Anemia	_____
Diabetes	_____	Epilepsy or Seizures	_____
Glaucoma	_____	Thyroid Disorder	_____
HIV or AIDS	_____	Cancers or Tumors	_____
Emotional Problems	_____	Chronic Infection	_____
Abnormal Scarring	_____	Radiation Treatments	_____

I have completed this medical information form to the best of my knowledge and acknowledge that all the above information is true.

Signature

____/____/____
Date