

MEDICAL HISTORY

Patient Name: _____

Have you or your immediate family had a history of:

	You	Family		You	Family
Allergies (Seasonal)	_____	_____	Heart Attack	_____	_____
Anemia	_____	_____	Hepatitis	_____	_____
Arthritis	_____	_____	Hernia	_____	_____
Asthma	_____	_____	High Blood Pressure	_____	_____
Back Trouble	_____	_____	Kidney/Bladder Disorders	_____	_____
Bronchitis	_____	_____	Leukemia	_____	_____
Cancer	_____	_____	Liver Disease	_____	_____
Cataracts	_____	_____	Pneumonia	_____	_____
Chest Pain	_____	_____	Prostate Trouble	_____	_____
Diabetes	_____	_____	Swelling	_____	_____
Emphysema	_____	_____	Ulcers	_____	_____
Gall Bladder	_____	_____			

Please list medications you are now taking:

MEDICATION	MG	MEDICATION	MG

Please list previous major illnesses and major surgeries and the approximate dates.

ILLNESSES	DATE	SURGERY	DATE

Are you allergic to any medications? If so, please list all of them.
