MEDICAL HISTORY

Please check YES or NO for each item listed.

If YES, furnish details including date and names of physicians

1. During the past 5 years have you:
    A. Been treated for any medical or surgical condition? ❑ Yes ❑ No
    B. Had an X-ray, electrocardiogram or laboratory test? ❑ Yes ❑ No
    C. Been advised to have an operation? ❑ Yes ❑ No
    D. Received prescription medication? If YES, give name and dosage.
    ❑ Yes ❑ No
2. Are you presently taking any prescription medications? ❑ Yes ❑ No
    If YES, give name and dosage.
3. Are you presently taking any non-prescription medications? ❑ Yes ❑ No
    If YES, give name and dosage.
4. Do you have any allergies to medications? ❑ Yes ❑ No
    If YES, give name and type of reactions.
5. Have you ever had a bad reaction to any medications? ❑ Yes ❑ No
    If YES, give name and type.
6. Has anyone in your family had or been treated for an emotional problem? ❑ Yes ❑ No
7. Do you drink coffee/tea/soda? ❑ Yes ❑ No
    If YES, how much?
8. Do you smoke? ❑ Yes ❑ No
    If YES, how much?
9. Do you drink alcohol? ❑ Yes ❑ No
    If YES, how much?
10. Except as prescribed by a physician, have you ever taken:
    A. Morphine, barbiturates, other narcotics?
    B. Heroin, cocaine, hashish, marijuana, amphetamines?
    C. Other drugs?

Family Physician: _____

Other Physicians currently seeing:_____

Number of emergency room visits last month: _____

Date of last physical. _____ If never, write NONE.

Date of last hospitalization. _____If never, write NONE.

Reason for hospitalization:_____

REVIEW OF SYMPTOMS

Have you ever had, or have been told you have had the following:

(If “have now” and “had in past”, check “Yes”)

Check one for each symptom

Frequent or severe headaches ❑ Yes ❑ No

Low blood pressure ❑ Yes ❑ No

Dizziness or fainting spells ❑ Yes ❑ No

Recent gain/loss or weight ❑ Yes ❑ No ❑ GAIN ❑ LOSS

Eye problems including glaucoma ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Head injury epilepsy or seizures ❑ Yes ❑ No
Thyroid trouble ❑ Yes ❑ No
Jaundice or liver disease ❑ Yes ❑ No
Asthma or shortness of breath ❑ Yes ❑ No
Kidney disease ❑ Yes ❑ No
Palpitation or pounding heart ❑ Yes ❑ No
Stroke ❑ Yes ❑ No
Heart attack/heart trouble ❑ Yes ❑ No
High blood pressure ❑ Yes ❑ No
MALES - prostate trouble ❑ Yes ❑ No
FEMALES - Are you currently pregnant or planning a pregnancy in the near future?
❑ Yes ❑ No
Please list any other disease or condition you may have that is not listed above: