

**MEDICAL HISTORY**

Do you have or have you been informed that you had any of the following:

- |                     |  |                      |  |
|---------------------|--|----------------------|--|
| Heart Condition     | Yes <input type="checkbox"/> No <input type="checkbox"/> | Ulcers/Digestive     | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| High Blood Pressure | Yes <input type="checkbox"/> No <input type="checkbox"/> | Artificial Joints    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Respiratory/Asthma  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Epilepsy/Fainting    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Rheumatic Fever     | Yes <input type="checkbox"/> No <input type="checkbox"/> | Glaucoma/Visual      | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Sinus Trouble       | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hepatitis A/B/C/D    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Ever use steroids   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Cancer/Chemotherapy  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Bleeding Hemophilia | Yes <input type="checkbox"/> No <input type="checkbox"/> | Alcoholism/Addiction | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Diabetes/Kidney     | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tuberculosis         | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Herpes              | Yes <input type="checkbox"/> No <input type="checkbox"/> | AIDS/HIV             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Thyroid             | Yes <input type="checkbox"/> No <input type="checkbox"/> | Mitrovalveprolapse   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Hormonal            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Murmur         | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Any other medical conditions not listed: Yes  No  Pregnant (Females) Yes  No

If yes, please list: \_\_\_\_\_

Please list all medications you are currently taking: Birth Control Pills Yes  No

\_\_\_\_\_  
\_\_\_\_\_

Please list all drug allergies you have:

\_\_\_\_\_  
\_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

In case of Emergency, please contact \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Business \_\_\_\_\_ Cell \_\_\_\_\_

Relationship \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_