Personal Medical History

(Please Print)

Name: Height: Weight:

Do you have, or had:	Yes	Family History	Related surgeries/complications/Informatic
Anemia			
Asthma			
Bleeding Disorders			Type:
Bone Injury/Fracture			Body Part(s):
Cancer			Type(s):
Chronic Pain			
Diabetes			Type I:___ Type II:___
Drug/Alcohol Abuse			How often?: How long?:
Epilepsy/seizures			
Gout			
Heart Arrhythmia or Murmur			Type:
Heart Disease			Type:
Heart Stents			
Hepatitis or Liver Disease			Type:
High Blood Pressure			
High Cholesterol			
Joint Problems/Arthritis			Body Part(s):
Kidney Disease			
Ligament/Tendon Injury			Body Part(s):
Lung Disease			Type:
Lyme Disease			
Nerve Problems			Type(s):
Rheumatologic Disease			Type(s):
Sickle Cell Anemia			
Thyroid disorders			
Tuberculosis			
Other:			

List any past surgeries you have had, including the year: _____

_____

List any medications (with doses) you are currently taking:_____

_____

_____

Do you smoke?: Yes:_____ No:_____ If yes, how many packs per day?:_____For how many years have you smoked?__

List any allergies, and your reaction:_____

_____

Are you allergic to latex?: Yes:_____ No:_____

What is the reaction?: Itching____ Swelling____ Hives____ Anaphylaxis____ Other:_____

Please list any other relevant information not yet mentioned :_____

Personal Medical History

(Please Print)

ation?

_____

_____

_____

_____

_____

ed?_____

_____

_____

_____