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MEDICAL HISTORY

Patient Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

Reason for today's visit: _____

Please check any of the following conditions that you now have (or have ever had):

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Abnormal Chest x-ray | <input type="checkbox"/> Blood clots in lung |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergy Problems | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Allergic reaction to
Local Anesthesia | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Faint easily |
| <input type="checkbox"/> Family history of skin
Cancer | <input type="checkbox"/> Joint pains/arthritis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Positive skin test for TB | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hepatitis |
| | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Artificial joints |
| <input type="checkbox"/> I take aspirin | <input type="checkbox"/> I take a blood thinner | <input type="checkbox"/> I take antibiotics
before surgical procedures |

I take the following medications/herbal supplements: _____

I am **allergic** to the following medications: _____

I drink _____ alcoholic beverages per week

I smoke _____ cigarettes per day

I **am/am not** pregnant

I **am/am not** now nursing

I have had the following surgeries: _____

I have the following medical conditions not mentioned above: _____

My personal physician is: _____

My pharmacy of choice is: _____

Completed by: Patient Parent Nurse

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