MEDICAL HISTORY CHART

Name: _____

Date of Birth: _____

Age: _____

Height: _____

Weight: _____

List All Previous Surgery with Dates:

_____

_____

_____

_____

_____

_____

List All Medications You are Currently Taking, with Dosages:

_____

_____

_____

_____

_____

_____

HAVE YOU HAD AN ADVERSE REACTION TO:

Anesthesia
Antibiotics
Codeine
Demerol
Adhesive tape
Aspirin
Sulfur
Penicillin
Valium
Iodine
Morphine
Suture material

DO YOU TAKE:

Blood pressure medication
Cardiac medication
Diet pills
Diuretics
Vitamins, herbal supplements
Tranquilizers
Alcohol
Sleeping pills
Anti-depressants
Pain medications
HRT
Aspirin or other anti-inflammatory drug

DO YOU HAVE A HISTORY OF:

Asthma
Bleeding disorders
Seizures, epilepsy
Hernia
Shortness of breath
Bronchitis, chronic cough
Tuberculosis
Depression
Osteo rheumatoid arthritis
Lupus or autoimmune disease
Hypertension
Blood clots
Diabetes
Headaches
Blood pressure medication
Cardiac medication
Thyroid disease
Hepatitis A B C
Mitral valve prolapse (heart murmur)
Drug abuse
Alcoholism

CANCER HISTORY:

Father
Mother
Siblings
Other relatives