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MEDICAL HISTORY FORM

Patient Name: _____

Primary Care Physician: _____

Date: _____

ALLERGIES: _____

HOSPITALIZATION/SURGERIES: _____

MEDICAL CONDITIONS	Y	N		Y	N
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Type _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Transplant Type _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Family History of Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Date of last Tetanus shot _____		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Stroke	<input type="checkbox"/>	<input type="checkbox"/>			

MEDICATION LIST

Do you take blood thinners? Yes or No

Medications you are currently taking:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Do you take **Aspirin** daily? Yes or No

Do you use Alcohol? Never _____ Socially _____ Daily _____

Do you smoke? Yes or No