Medical History

Patient Name and Date: ______________________

Please fill Out HONESTLY and COMPLETELY:

Have YOU had any of the following illnesses: (Please Check)

Measles____	Diabetes___	Typhoid___	Other Not Listed:
Rubella____	Depression___	Goiter____	
Chickenpox____	Lupus___	Hives____	
Mumps____	Allergies____	Hepatitis___	
Whooping Cough___	Eczema____	Venereal Disease____	
Scarlet Fever___	Mono___	Seizures___	
Tonsillitis___	Rheumatic Fever__	Meningitis___	
Diphtheria___	Poliomyelitis___	Ear Infections___	
Asthma___	Pleurisy___	Heart Murmur___	
Glaucoma____	Bronchitis___	High Blood Pressure___	
Cancer____	Influenza___	Low Blood Pressure___	
Angina Pectoris___	Tuberculosis___	Heart Attack___	
Ulcers___	Bladder Infections_	Kidney Stones____	

Please check if any FAMILY MEMBERS have any of the following:

Alcoholism___	Lupus___	Genetic diseases___	Other Not Listed:
Hay Fever___	Anemia___	Glaucoma___	
Anesthesia problem__	Arthritis___	Hearing problems___	
Arthritis___	Heart Attack___	High Blood Pressure___	
Birth Defects___	Bleeding Problems_	High Cholesterol___	
Cancer___	Kidney diseases__	Osteoarthritis___	
Mitral Valve Prolapse_	Depression___	Osteoporosis___	
Stroke___	Eczema___	Rheumatoid Arthritis___	
Diabetes Type 1___	Diabetes Type 2__	Thyroid Disorders___	