MEDICAL HISTORY

PATIENT'S NAME: ______________________________ DATE: ________________

	YES	NO
Have you been ill recently? EXPLAIN:		
Have you ever been hospitalized? EXPLAIN:		
Are you under the care of a Physician? EXPLAIN:		
Have you ever had surgery? EXPLAIN:		
Do you smoke? How many packs per day?		
Do you drink alcohol? How much?		
Do you have asthma? When was the last episode?		
Rheumatic Fever?		
Heart Attack (Heart Disease or Murmur) if so when? How many?		
High Blood Pressure?		
Anemia?		
Stroke? If so when?		
Jaundice?		
Diabetes? Type#1 or Type#2?		
Epilepsy? Type? Last episode?		
Tuberculosis?		
Venereal Disease?		
Are taking medications now? Enter ALL medications on a separate LIST.		
Are you allergic to penicillin? Or any other medications? List below;		
Do you have prolonged bleeding?		
Are you PREGNANT OR NURSING? Circle one if applicable.		

NAME & ADDRESS OF YOUR PHYSICIAN: ________________________________

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SHOE SIZE__________ ________________________________

PHONE # ________________________________

PATIENT SIGNATURE: ______________________ DATE: __________________

UNIVERSAL MEDICATION FORM

Name:	Date Form Started:
Phone Number:	Address:
Birth Date:	

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription Vitamin and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko).Include medications taken as needed (example: nitroglycerin).

DATE	NAME OF MEDICATIONS/DOSE	DIRECTIONS: (How many times a day do you take this and when.)	DATE STOPPED	NOTES: Reason for taking/Doctor