## MEDICAL HISTORY

MEDICAL DOCTOR'S NAME		DOCTOR'S PHONE		
ARE YOU CURRENTLY UND	ER A DOCTOR'S CARE? IF Y	ES, FOR WHAT REASON?		
ARE YOU CURRENTLY TAKE	ING ANY MEDICATIONS? IF	YES, PLEASE SPECIFY:		
ARE YOU ALLERGIC TO AN	Y MEDICATIONS OR SUBSTA	ANCES? IF YES, PLEASE SPECIF	FY:	
ARE YOU PREGNANT? YES_	NO DUE DATE_	DO YOU SM	MOKE? YESNO	
DO YOU USE SMOKELESS T	OBACCO?			
		CAL CONDITIONS APPLY TO		
HEART TROUBLE	ASTHMA	TUBERCULOSIS	GLAUCOMA	
HIGH BLOOD PRESSURE	EMPHYSEMA	LIVER DISEASE	PSYCHIATRIC CARE	
LOW BLOOD PRESSURE	LUNG DISEASE	YELLOW JAUNDICE	BLOOD TRANSFUSION	
HEART MURMUR	BLOOD DISEASE	HEPATITIS A/B/OTHER	HEMOPHILIA	
MITRAL VALVE PROLAPSE	ANEMIA	HIV POSITIVE	VENEREAL DISEASE	
RHEUMATIC FEVER	DIABETES	AIDS	FAINTING/DIZZINESS	
CONGENITAL HEART	HYPOGLYCEMIA	CANCER	PROLONGED BLEEDING	
LESION	STROKE	THYROID DISEASE	SINUS TROUBLE	
ARTIFICIAL HEART VALVE	ARTFICIAL JOINT/HIPS	CHEMOTHERAPY	EPILEPSY/SEIZURES	
HEART PACEMAKER	KIDNEY TROUBLE	RADIATION TREATMENT	ARTHRITIS	
HEART SURGERY	ULCERS			
HAVE VOLUMD AND OTHE	ED CEDIOUS II I NECCES NOT	LICTED ABOVES IF VEC DIEA	CD CDDCHEV.	
HAVE TOO HAD ANT OTHE	K SEKTOOS ILLINESSES NOT	LISTED ABOVE: IF 1ES, PLEA	SE SPECIFY:	
DO YOU WISH TO TALK TO	THE DOCTOR PRIVATELY	ABOUT ANY PROBLEM? YES_	NO	
		IRE:		
REVIEWED BY:			DATE:	
RECARE: I HAVE REVIEWE	ED THE ABOVE MEDICAL HI	STORY AND HAVE NOTED AN	IY CHANGES.	
CHANGES? DATE: PT: REVIEW	WED BY:   DATE: LIST CHAN	IGES:		
Y/N				