# MEDICAL HISTORY

NAME: ______________________________ DOB: __________

***Do you have or have you ever had?***

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| TUBERCULOSIS | ☐ | ☐ | FREQUENT HEADACHES | ☐ | ☐ |
| CHRONIC COUGH | ☐ | ☐ | NERVOUS BREAKDOWN | ☐ | ☐ |
| ASTHMA | ☐ | ☐ | HEAD INJURY | ☐ | ☐ |
| HAYFEVER | ☐ | ☐ | FAINTING SPELLS | ☐ | ☐ |
| FREQUENT COLDS | ☐ | ☐ | HEART TROUBLE | ☐ | ☐ |
| CHEST PAINS | ☐ | ☐ | HIGH BLOOD PRESSURE | ☐ | ☐ |
| BLOOD SPITING | ☐ | ☐ | DIABETES | ☐ | ☐ |
| BRONCHITIS | ☐ | ☐ | FREQUENT EAR ACHES | ☐ | ☐ |
| PNEUMONIA | ☐ | ☐ | FREQUENT SORE THROAT | ☐ | ☐ |
| NOSE BLEEDS | ☐ | ☐ | KIDNEY TROUBLE | ☐ | ☐ |
| SHORTNESS OF BREATH | ☐ | ☐ | VENEREAL DISEASE | ☐ | ☐ |
| JAUNDICE | ☐ | ☐ | DIFFICULT URINATION | ☐ | ☐ |
| MALARIA | ☐ | ☐ | RECTAL TROUBLE | ☐ | ☐ |
| GOUT | ☐ | ☐ | CHRONIC CONSTIPATION | ☐ | ☐ |
| TYPHOID FEVER | ☐ | ☐ | HERNIA (RUPTURE) | ☐ | ☐ |
| RHEUMATISM | ☐ | ☐ | STOMACH ULCERS | ☐ | ☐ |
| POLIO | ☐ | ☐ | BACKACHE OR SPRAIN | ☐ | ☐ |
| PARALYSIS | ☐ | ☐ | CANCER/TUMORS | ☐ | ☐ |
| ARTHRITIS | ☐ | ☐ | SKIN TROUBLE | ☐ | ☐ |
| PLEURISY | ☐ | ☐ | VARICOSE VEINS | ☐ | ☐ |
| SWOLLEN GLANDS | ☐ | ☐ | EPILEPSY/SEIZURE | ☐ | ☐ |
| HEPATITIS | ☐ | ☐ | | | |

Do you take medication daily? Yes ☐ No ☐ if yes, please list: ______________________________

______________________________

Have you had any operations? Yes ☐ No ☐ if yes,what type? ______________________________

______________________________

Do you smoke? Yes ☐ No ☐ if yes, how much? _____ packs/day. How many years have you smoked? ________

Do you drink? Yes ☐ No ☐ if yes, how much? ______________ How often? __________

**Please state the age and health status of these relatives:**

| | Age | Health | | Age | Health |
|---|---|---|---|---|---|
| Grandfather | | | Brother | | |
| Grandmother | | | Sister | | |
| Father | | | Child | | |
| Mother | | | Child | | |

**On your next visit, please bring your immunization record.**

**Signature** ______________________ **Date** ____________