MEDICAL HISTORY FORM

Name _____

Home Address _____

Phone _____ **Birthdate** _____

HEALTH HISTORY

Any history, past or present of:	YES	NO
Head or back injuries	_____	_____
Convulsions or other neurological disorders	_____	_____
Heart disease, high blood pressure, or rheumatic fever	_____	_____
Lung disorders – asthma, tuberculosis	_____	_____
Stomach, gall bladder, or other gastro-intestinal disorders	_____	_____
Allergies – food, drug, plants, etc.	_____	_____
Anemia	_____	_____
Kidney trouble	_____	_____
Venerial disease	_____	_____
Diabetes or other glandular disorders	_____	_____
Surgery	_____	_____
Genital problems	_____	_____
Psychological disorders	_____	_____
Permanent defect	_____	_____

If any of above answered yes, please elaborate: _____

_____

What do you consider your state of health: Excellent _____ Good _____ Fair _____ Poor _____

To the best of my knowledge, the above information is correct.

_____ _____

Patient's Signature Date