MEDICAL HISTORY

NAME _____ DATE _____

DATE OF YOUR LAST PHYSICAL EXAMINATION _____ WEIGHT _____ HEIGHT _____

PRIMARY CARE PHYSICIAN _____

ADDRESS _____

PHONE NUMBER _____ FAX NUMBER _____

SURGERY (OPERATIONS AND COSMETIC SURGERY)

	TYPE	DATE	COMPLICATIONS OR DIFFICULTIES
1.			
2.			
3.			
4.			
5.			
6.			

MEDICAL PROBLEMS OR CONDITIONS NOW UNDER TREATMENT BY A PHYSICIAN

EXPLAIN _____

ADMISSIONS TO HOSPITAL

	REASON	DATE	COMPLICATIONS OR DIFFICULTIES
1.			
2.			
3.			
4.			

MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE NOW

	TYPE	DOSAGE/AMOUNT IF KNOWN	TAKE HOW OFTEN
1.			
2.			
3.			
4.			

CONSUMPTION OF THE FOLLOWING

ASPIRIN	AMOUNT DAILY		AMOUNT WEEKLY
ALCOHOL	AMOUNT DAILY		AMOUNT WEEKLY
TOBACCO	AMOUNT DAILY		AMOUNT WEEKLY
OTHERS	AMOUNT DAILY		AMOUNT WEEKLY

BLEEDING PROBLEMS

DO YOU BRUISE OR BLEED EASILY? YES NO (WITH CUTS / TOOTH EXTRACTIONS / PREGNANCY / SURGERY)

EXPLAIN _____

DO YOU HAVE A FAMILY HISTORY OF BLEEDING PROBLEMS? EXPLAIN _____

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA

EXPLAIN _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO **ARE YOU PREGNANT?** YES NO

HAVE YOU EVER HAD, HAVE OR BEEN EXPOSED TO (PLEASE CIRCLE YES OR NO)

INTRAVENOUS DRUGS NO ☐ YES ☐ **HEPATITIS** NO ☐ YES ☐ **INFECTIOUS DISEASES** NO ☐ YES ☐

CONTINUE ON NEXT PAGE

HIV /AIDS NO ☐ YES ☐ **TB** NO ☐ YES ☐ **LIVER TRANSPLANT** NO ☐ YES ☐

IF YES TO ANY EXPLAIN _____

_____

HISTORY OF EPILEPSY OR MENTAL ILLNESS

EXPLAIN _____

_____

CHILDHOOD MEDICAL HISTORY (PLEASE CIRCLE YES, NO OR UNCERTAIN)

HAD ALL KNOWN "BABY SHOTS"? YES NO UNCERTAIN HAD POLIO IMMUNIZATION? YES NO UNCERTAIN

HAD RHEUMATIC FEVER? YES NO UNCERTAIN

FAMILY HISTORY

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

MOTHER _____ SISTER _____

_____ _____

FATHER _____ BROTHER _____

_____ _____

OTHER RELATIVE: _____

REVIEW OF SYSTEMS

ANY MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING:

HEAD NO ☐ YES ☐ **EYES** NO ☐ YES ☐ **EARS** NO ☐ YES ☐

THYROID NO ☐ YES ☐ **LUNGS** NO ☐ YES ☐ **HEART** NO ☐ YES ☐

BLOOD PRESSURE/VESSELS NO ☐ YES ☐ **DIGESTIVE SYSTEM** NO ☐ YES ☐ **LIVER** NO ☐ YES ☐

MUSCLE-BONES NO ☐ YES ☐ **REPRODUCTIVE ORGANS** NO ☐ YES ☐ **KIDNEYS-BLADDER** NO ☐ YES ☐

UNSIGHLTY SCARS NO ☐ YES ☐ **IMMUNE SYSTEM** NO ☐ YES ☐ **OTHER** NO ☐ YES ☐

IF YES TO ANY PLEASE EXPLAIN _____

_____

ALLERGIES, PLEASE LIST

_____

_____

Weight	lbs	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	220
	kgs	45.4	47.6	49.9	52.2	54.4	56.7	59.0	61.2	63.5	65.8	68.0	70.3	72.6	74.8	77.1	79.4	81.6	83.9	86.2	88.5	90.7	93.0	95.3	97.5	99.8
Height	in/cmts	Underweight						Healthy					Overweight											Extremely Obese		
60	152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	41	42
61	154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	34	35	36	37	38	39	40	41
62	157.5	18	19	20	21	21	22	23	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38	39	40
63	160.0	17	18	19	20	21	22	23	23	24	25	26	27	28	29	30	30	31	32	33	34	35	36	37	38	38
64	162.6	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	30	31	32	33	34	35	36	36	37
65	165.1	16	17	18	19	19	20	21	22	23	24	24	25	26	27	28	29	29	30	31	32	33	34	34	35	36
66	167.6	16	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	33	34	35
67	170.2	15	16	17	18	18	19	20	21	21	22	23	24	25	25	26	27	28	28	29	30	31	32	32	33	34
68	172.7	15	15	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31	32	33
69	175.3	14	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31	32
70	177.8	14	15	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	27	28	29	30	30	31
71	180.3	13	14	15	16	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	27	28	29	29	30
72	182.9	13	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29	29
73	185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29
74	188.0	12	13	14	14	15	16	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	26	27	28
75	190.5	12	13	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	24	25	26	26	27
76	193.0	12	12	13	13	14	15	15	16	17	17	18	18	19	20	20	21	21	22	23	23	24	24	25	26	26

_____ _____ _____

REVIEWED BY: PRINT NAME SIGNATURE DATE/TIME