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**MEDICAL HISTORY
 INFORMATION SHEET**

NAME: _____ Date of this visit: _____

DRUG ALLERGIES: _____

FAMILY PHYSICIAN: _____ REFERRING PHYSICIAN: _____

MEDICAL HISTORY: Please check "Yes" or "No" to the following, as it pertains to you:

Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Replacement <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take Aspirin? <input type="checkbox"/> Yes <input type="checkbox"/> No	Congestive Heart Failure <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Taking Coumadin/Plavix <input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No	Stent <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what year?
Blood disease/disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Defibrillator <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Valve Replacement <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiologist <input type="checkbox"/> Yes <input type="checkbox"/> No	Cold sores/fever blisters <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No

Do you require antibiotics prior to procedures? Yes No
 Do you smoke or use tobacco products? Yes No
 Do you drink alcohol? Yes No

MEDICATIONS – Include dosages, all over-the-counter meds, vitamins and herbal supplements:

SURGERIES:

Please provide nursing staff with any changes of medical status.