CONFIDENTIAL

MEDICAL HISTORY

PATIENT NAME _____ **DATE OF BIRTH**_____

DATE OF LAST PHYSICAL EXAM_____

LIST OF PRESCRIPTION MEDICATIONS_____

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LIST OF NON-PRESCRIPTION MEDICATIONS_____

ALLERGIES TO MEDICATIONS_____

LIST OF CHRONIC DISEASES ☐ ASTHMA ☐ COPD ☐ SLEEP APNEA ☐ NARCOLEPSY ☐ALLERGIES ☐ RESTLESS LEGS
☐ HEART DISEASE ☐ DIABETES ☐ HYPERTENSION ☐ HYPERCHOLESTEROLEMIA ☐ LUNG CANCER ☐ BLEEDING TENDENCY
☐ DEPRESSION ☐ OTHER_____

RECENT HOSPITALIZATIONS_____

SURGERIES_____

IMMUNIZATION HISTORY _____

FAMILY HISTORY ☐ ASTHMA ☐ COPD ☐ SLEEP APNEA ☐ NARCOLEPSY ☐ALLERGIES ☐ RESTLESS LEGS
☐ HEART DISEASE ☐ DIABETES ☐ HYPERTENSION ☐ LUNG CANCER ☐ BLEEDING TENDENCY ☐ DEPRESSION
☐TUBERCULOSIS ☐ OTHER_____

CERTIFICATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

_____ _____
Signature of Patient or Patient Guardian or Patient Representative Date

_____ _____
Please print name of Patient, Guardian or Patient Representative Relationship to Patient