MEDICAL HISTORY

		CIRCLE
1.	Have you been a patient in hospital during the past two years?	YES NO
2.	Have you been under the care of a medical doctor during the past two years?	YES NO
3.	Are you taking any pills, medications or drugs (including aspirin) or other non-prescription drugs? List____	YES NO
4.	When was your last physical examination?	_______
5.	Are you allergic to or have had a reaction from penicillin, aspirin, codeine or any other type of drug or medication?	YES NO
6.	Have you ever had any excessive bleeding requiring special treatment?	YES NO
7.	Do you smoke? Currently Previously Never	
8.	Circle any of the following which you have had or have at present:	

Heart failure	Rheumatic Fever	Heart Pace Maker
Emphysema	Pacemaker	Chemotherapy (Cancer)
HIV Positive	Hemophilia	Fainting or Dizzy Spells
Heart Disease/Attack	Rheumatic Heart Disease	Heart Surgery
Persistent Cough	Sinus Trouble	Arthritis
Hepatitis Type A (infectious)	Venereal Disease (Syphilis, Gonorrhea)	Nervousness
Ulcers		Artificial Joint
Hay Fever	Heart Murmur	Rheumatism
B (serum), C or D	Allergies /Hives	Psychiatric Treatment
Angina Pectoris	Drug Addiction	Anemia
Tuberculosis	Congenital Heart Defect	Cortisone Medicine (Steroid
Liver Disease	Diabetes	Sickle Cell Disease
High Blood Pressure	Cold Sores	Stroke
Asthma	Scarlet Fever	Glaucoma
Yellow Jaundice	Thyroid Disease	Bruise Easily
Low Blood Pressure	Genital Herpes	Pain in Jaw Joints
AIDS	Artificial Heart Valve	
Blood Transfusion	X-Ray or Radiation Therapy	
	Epilepsy or Seizures	

9.	When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?		YES NO
10.	10. Do your ankles swell during the day?		YES NO
11.	11. Do you use more than 2 pillows to sleep?		YES NO
12.	12. Have you gained more than 10 lbs in the last year?		YES NO
13.	13. Do you ever wake up from sleep short of breath?		YES NO
14.	14. Are you on a special diet?		YES NO
15.	15. Has your medical doctor ever said you had cancer or a tumor?		YES NO
16.	16. Do you have disease, condition or problem not listed		YES NO
17.	17. Are you under abnormal stress? e.g. marital, business or social		YES NO
18.	18. WOMEN:	Are you pregnant?	YES NO
		Are you taking oral contraceptives?	YES NO
		Do you anticipate becoming pregnant?	YES NO
		Have you reached menopause?	YES NO

To the best of my knowledge, all of the preceding questions are true and correct. If I ever have any change in my health or if my medications change, I will inform Dr. Corbett without fail.

_________________________________ _________________________________

Date Signature of Patient, Parent or Guardian