MEDICAL DATA SHEET

DATE _____ REDORD NO._____

NAME: _____ **RACE**: _____ **SEX**: **M F** **AGE**: _____
last first middle

OCCUPATION: _____

REASON FOR THIS OFFICE VISIT: _____

INJURY RELATED? YES NO IF YES, DATE _____

LIST OF ALL MEDICATIONS (also include over-the-counter medications, sprays, or inhalers):

_____
_____
_____
_____
_____
_____
_____

SURGERY, HOSPITALIZATIONS, ENDOSCOPIES, SERIOUS INJURIES, OR RADIATION:

DATE BRIEF DESCRIPTION WHERE? DOCTOR

_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES: _____
(to medication and other allergies)

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS OR PROBLEMS: (Please check Yes or No)

	Yes	No		Yes	No		Yes	No		Yes	No
heart disease	☐	☐	reaction to anesthesia	☐	☐	blood disorder	☐	☐	loud noise exposure	☐	☐
high blood pressure	☐	☐	seizures	☐	☐	ulcers	☐	☐	hearing loss	☐	☐
cancer	☐	☐	nervous illness	☐	☐	liver disease	☐	☐	hay fever	☐	☐
diabetes	☐	☐	alcoholism	☐	☐	high cholesterol	☐	☐			
asthma	☐	☐	kidney disease	☐	☐	high triglycerides	☐	☐	recent cough	☐	☐
stroke	☐	☐	bleeding tendency	☐	☐	tuberculosis	☐	☐	recent chest pain	☐	☐
emphysema	☐	☐	blood clots	☐	☐	thyroid disease	☐	☐	other (specify):		
chronic bronchitis	☐	☐									

HABITS: Amount of alcohol per week: _____

Non-Smoker Current Smoker Previous Smoker

FAMILY HISTORY (any blood relatives with these conditions? (Please indicate father, mother, brother or sister)

bleeding tendency	reaction to anesthesia	diabetes	cancer	asthma
heart disease	blood disorder	hay fever	stroke	seizure
sickle cell	high blood pressure	TB	hearing loss	other (specify):