Patient Medical History

Are you currently under a Doctor's care?
Do you exercise on a regular basis?
Do you use tobacco?
Have you been hospitalized for any surgical operation or serious illness within the last 5 years?
*If yes, please explain: _______________
____
____

Do you use alcohol?
*If so, how much? _________
Are you pregnant?
Are you taking medications?
*If yes, what medication(s) are you taking?
____
____
____
____

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Abnormal blood test	___	___	Epilepsy/Convulsions	___	___	Lung infections, frequent	___	___
AIDS or HIV infection	___	___	Eye problems, seizures	___	___	Malignant Disease	___	___
Anemia	___	___	Fainting, seizures	___	___	Neuro: Dizziness	___	___
Angina	___	___	Frequently tired	___	___	Numbness	___	___
Arthritis	___	___	Glaucoma	___	___	Tingling	___	___
Asthma	___	___	Hay Fever, Allergies	___	___	Radiation Therapy	___	___
Bronchitis	___	___	Hepatitis, Jaundice	___	___	Recent Weight Loss	___	___
Cancer	___	___	Heart Attack	___	___	Respiratory Problems	___	___
Cardiac Pacemaker	___	___	Heart Disease	___	___	Rheumatic Fever	___	___
Chest Pains	___	___	Heart Murmur	___	___	Rosacea	___	___
Claustrophobia	___	___	Heart Problems	___	___	Seizure Disorders	___	___
Contact Lenses	___	___	Herpes	___	___	Shortness of Breath	___	___
COPD	___	___	High Blood Pressure	___	___	Stomach Problems – Ulcer	___	___
Cough, chronic	___	___	Infections, frequent	___	___	Stroke	___	___
Dentures	___	___	Joint Replacement, Implant	___	___	Swollen Ankles	___	___
Diabetes	___	___	Kidney Disease	___	___	Thoracic Surgery	___	___
Drug Use	___	___	Leukemia	___	___	Thyroid Problem	___	___
Ear problems, surgeries	___	___	Liver Disease	___	___	Tuberculosis	___	___
Easily winded	___	___	Low Blood Pressure	___	___	Other	___	___
Emphysema	___	___	Lung Disease	___	___	Other	___	___

Do you have a history of spontaneous pneumothorax?	___	___
Have you had chemotherapy?	___	___
Do you have problems with your ears when you fly?	___	___
Do you have problems going up and down in an elevator?	___	___
Do you have back problems?	___	___

I certify that the above questions have been accurately answered. I authorize the release of any medical information from my chart to any physician or physicians who may be involved in my medical treatment.

____
Print Patient Name

____
Date

____
Patient Signature