MEDICAL HISTORY & PHYSICAL EXAM FORM

Name: _____ Address: _____
Birth Date: ___/___/___ _____
In the event of emergency contact: _____
1. Name: _____ Phone #: (___) _____
2. Name: _____ Phone #: (___) _____

Any vehicle mishaps in previous year? Yes ☐ No

Allergies: _____

Medicines: _____

Medical Conditions:

Hospitalizations:	Reason	Approximate Year

Previous Operations:

Current Symptoms:

Syncope (fainting)	☐ Yes	☐ No	Irregular heart beat	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Chest pain	☐ Yes	☐ No
Vertigo (dizziness)	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Decreased hearing	☐ Yes	☐ No	Vision Change	☐ Yes	☐ No

Numbness:			**paresis (significant weakness):**		
Arms	☐ Yes	☐ No	Arms	☐ Yes	☐ No
Legs	☐ Yes	☐ No	Legs	☐ Yes	☐ No