MEDICAL HISTORY

First name | Last name | Date of Birth

Family physician | Physician contact number

Are you currently under a physician's care? . . . . . Yes ☐ No ☐

May we request your health records if needed? . . . . . Yes ☐ No ☐

Are you currently taking any medications? . . . . . Yes ☐ No ☐

If yes, what medications are you currently taking (please list)

Circle any of the following that you have had or have at present:

HEART DISEASE	CANCER	ASTHMA
CHEMOTHERAPY OR RADIATION	FAINTING	HEART MURMUR
JOINT REPLACEMENT	NERVOUSNESS	ARTIFICIAL HEART VALVE
PAIN IN JAW	EPILEPSY OR SEIZURES	HEART ATTACK
HEART SURGERY/PACEMAKER	DIABETES	BRUISE EASILY
BACTERIAL ENDOCARDITIS	ULCERS	HIV OR AIDS
CONGENITAL HEART LESIONS	TUBERCULOSIS (TB)	ARTHRITIS
ABNORMAL BLOOD PRESSURE (HIGH OR LOW)	KIDNEY DISEASE	DRUG ADDICTION
HEMOPHILIA (ABNORMAL BLEEDING)	GLAUCOMA	HEPATITIS A, B OR C
SICKLE CELL DISEASE	RHEUMATIC FEVER	HAY FEVER
SINUS TROUBLE	ANEMIA	EMPHYSEMA
PSYCHIATRIC TREATMENT	LIVER DISEASE	DIZZY SPELLS
UNEXPLAINED WEIGHT LOSS	STROKE	RHEUMATISM
STI (GONORRHEA OR SYPHILIS)		

Are you allergic or have you reacted adversely to any of the following listed below:

ASPIRIN PENICILLIN ERYTHROMYCIN CODEINE
LATEX PERCODAN LOCAL ANESTHETIC

Are you aware of being allergic to any other medications? . . . . . Yes ☐ No ☐

If yes, please explain

Are you pregnant at this time? . . . . . Yes ☐ No ☐

If yes, how many months?

Have you ever had a serious illness requiring hospitalization or surgery?

I understand that an electronic copy of my signature and the information I have provided will be created. This electronic copy will serve as a genuine copy of my original signature and may be used in place of original for any purpose.

SIGNATURE DATE

WITNESS (PRINT)