

MEDICAL HISTORY

Patient's Last Name \_\_\_\_\_ MI \_\_\_ First Name \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No

For what reason? \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ Last time seen \_\_\_\_\_

Have you ever been hospitalized?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you taking any prescription medication?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you taking any over the counter medication?  Yes  No

If yes, please explain: \_\_\_\_\_

Do you have any allergies?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you allergic to any medications or substances?  Yes  No

If yes, please explain: \_\_\_\_\_

Do you have any problems with antibiotics or anesthetics?  Yes  No

If yes, please explain: \_\_\_\_\_

Do you take appetite suppressants?  Yes  No Name of product: \_\_\_\_\_

**Have you ever had any of the following diseases or medical conditions?**

- |  |                         |  |                         |
|--|-------------------------|--|-------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Stroke     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcohol/Drug Abuse      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer/Chemotherapy     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/AIDS                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Transfusion       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B             | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis C             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis D             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney problems         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Valves       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Bones/Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Severe Headaches        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty Breathing    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Surgery           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes Type I           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pace Maker              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes Type II          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Problems    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you consume alcohol? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you smoke?           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hip/knee replacement    |

**Are you allergic to any of the following?**

- |  |                       |  |                       |
|--|-----------------------|--|-----------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Codeine               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Aspirin               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tetracycline          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Erythromycin          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Germicides/Pesticides |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex/Rubber Products | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other                 |

**For Women Only:**

- |  |                            |  |                              |
|--|----------------------------|--|------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Taking Birth Control Pills | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pregnant / # of Months _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Nursing?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hormone Therapy              |

Signature \_\_\_\_\_ Date \_\_\_\_\_