Medical History

Patient Name: _____
Date of Birth: _____

Physician: Name_____
Telephone _____
Address _____

Date of last physical examination:
_____
Pharmacy number:
_____

Do you have or had any of these medical conditions?

Y	N	ALLERGIES
□	□	Local Anesthetic
□	□	Aspirin
□	□	Latex
□	□	Ibuprofen
□	□	Penicillin
□	□	Acetaminophen(Tylenol)
□	□	Codeine/ Narcotics
□	□	Others _____
		_____

Y	N	CARDIOVASCULAR
□	□	High blood pressure
□	□	Angina (chest pain)
□	□	Heart attack
□	□	Irregular heart beat
□	□	Heart surgery
□	□	Heart failure
□	□	Damaged heart valve
□	□	High cholesterol
□	□	Heart infection
□	□	Stroke
□	□	Congenital heart disease
□	□	Heart murmur
□	□	Heart disease
□	□	Low blood pressure
□	□	Pace maker
□	□	Artificial valve

Y	N	ENDOCRINE
□	□	Diabetes
□	□	Thyroid problem
□	□	Hypoglycemia
□	□	Parathyroid Disease

Y	N	EYES/ EARS
□	□	Glaucoma
□	□	Impaired vision
□	□	Impaired hearing

Y	N	GASTROINTESTINAL
□	□	Acid reflux/ GERD
□	□	Irritable bowel syndrome
□	□	Stomach ulcer

Y	N	HEMATOLOGIC
□	□	Anemia
□	□	Sickle cell anemia
□	□	Abnormal bleeding
□	□	Blood disease
□	□	Blood transfusion
□	□	Leukemia
□	□	Bruise easily
□	□	Prolonged bleeding from Cut/ injury

Y	N	HEPATIC
□	□	Liver disease
□	□	Jaundice
□	□	Hepatitis
□	□	Hepatitis A
□	□	Hepatitis B or C
□	□	Mononucleosis

Y	N	IMMUNE
□	□	Past use of steroids
□	□	Delayed healing
□	□	Hay Fever
□	□	Hive / Rash
□	□	Immune System Problem
□	□	Rheumatic Fever

Y	N	INFECTIONS
□	□	HIV Positive/ AIDS
□	□	Sexually Transmitted Disease
□	□	Shingles
□	□	Herpes

INFECTIONS (cont)		
Y	N	
□	□	Tuberculosis
□	□	TB Test Positive

Y	N	MALIGNANCY
□	□	Tumor
□	□	Cancer
□	□	Chemotherapy
□	□	Radiotherapy

Y	N	MENTAL HEALTH
□	□	Bipolar Disorder
□	□	Depression
□	□	Anxiety
□	□	Eating Disorder
□	□	Sleep Disorder
□	□	Dementia
□	□	Learning Disorder
□	□	Psychiatric Treatment
□	□	Mental Health Disturbance

Y	N	MUSCULOSKELETAL
□	□	Arthritis/ Gout
□	□	Artificial joint/ Prosthetic
□	□	Fibromyalgia
□	□	Lupus
□	□	Sjogren's System
□	□	Osteoporosis
□	□	Leukemia
□	□	Swelling of Limbs

Y	N	NEUROLOGIC
□	□	Epilepsy/ Seizures
□	□	Parkinson's Disease
□	□	Multiple Sclerosis
□	□	Headaches

Y	N	FEMALES
□	□	Pregnant
□	□	Nursing
□	□	Birth Control Pills

Y	N	RESPIRATORY
□	□	Asthma
□	□	Sleep Apnea
□	□	Difficult Breathing
□	□	Emphysema

Y	N	RENAL
□	□	Kidney Problems
□	□	Dialysis

Y	N	OTHERS
□	□	Tobacco Use
□	□	Alcohol
□	□	Chemical Dependent
□	□	Recreation Drugs

List of medications:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
If more, please write on the back.

Please list any disease, condition, or problem you have that is not listed above. Also, list any hospitalizations or surgeries you have had. _____
_____

Medical History Acknowledgement

I understand that the information in the Medical History I have given is correct and to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and that you have my permission to ask the respective health care provider or agency for further information if needed. It is my responsibility to inform this office of any changes in my health or medications.

Signature:_____ Relationship to patient: _____ Date: _____
Doctor Signature: _____ Date: _____