PATIENT MEDICAL HISTORY

NAME_____**HOME PHONE**_____

WORK PHONE_____ **CELL PHONE/PAGER** _____

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

SEX ___ **SS#** _____ - ____ - _____ **BIRTHDATE** _____/____/_____ **DRIVERS LIC. #** _____

OCCUPATION _____ **EMPLOYER** _____

EMPLOYER'S ADDRESS _____

NAME OF PHYSICIAN_____**LAST PHYSICAL**_____

ARE YOU UNDER MEDICAL TREATMENT NOW? YES_____ NO_____

IF YES, FOR WHAT CONDITION?_____

ARE YOU TAKING ANY MEDICATIONS? YES_____ NO_____ HEIGHT_____WEIGHT_____

IF YES, WHAT MEDICATIONS ARE YOU TAKING?_____

_____

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING:

(USE A CHECK MARK TO INDICATE YES)

_____LOCAL ANESTHETICS (NOVACAINE)

_____PENICILLIN/ANTIBIOTICS

_____IODINE

_____ASPIRIN

_____LATEX

_____CODEINE

_____SULFA

_____OTHER

WOMEN ONLY: _____ ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?

_____ ARE YOU TAKING BIRTH CONTROL PILLS?

_____ ARE YOU ON HORMONE REPLACEMENT THERAPY?

DO YOU HAVE OR HAVE YOU HAD THE FOLLOWING?

_____STOMACH ULCERS

_____HIGH BLOOD PRESSURE

_____PROSTHETIC JOINT REPLACEMENT

_____SEXUALLY TRANSMITTED DISEASE

_____LOW BLOOD PRESSURE

_____AIDS/HIV

_____RADIATION TREATMENT

_____ANEMIA

_____MENTAL ILLNESS

_____EMPHYSEMA

_____DIABETES

_____THYROID PROBLEMS

_____RHEUMATIC FEVER

_____ASTHMA

_____CIRCULATORY PROBLEMS

_____SINUS PROBLEMS

_____DO YOU USE RECREATIONAL DRUGS?

_____TUBERCULOSIS: ____ACTIVE?

_____DATE OF LAST NEGATIVE "ACID TEST"

_____CURRENTLY HAVE A COUGH?

_____MITRAL VALVE PROLAPSE

_____TUMORS

_____HEART ATTACK

_____MALIGNANCIES

_____HEPATITIS

_____HEART MURMUR

_____ABNORMAL BLEEDING

_____ARTHRITIS

_____USED TOBACCO

_____SEIZURES

_____HEART VALVE PROBLEMS

_____SCARLET FEVER

_____CHEMOTHERAPY

_____HEART DISEASE

_____TYPHOID FEVER

_____ARE YOU IN RECOVERY?

_____ STROKE

_____ OTHER

_____

_____

_____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

SIGNATURE_____**DATE**_____

PLEASE DOCUMENT UPDATES ON REVERSE SIDE