

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) _____ LATEX
_____ PENICILLIN/ANTIBIOTICS _____ CODEINE
_____ IODINE _____ SULFA
_____ ASPIRIN _____ 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	_____ MITRAL VALVE PROLAPSE
_____ HIGH BLOOD PRESSURE	_____ TUMORS
_____ PROSTHETIC JOINT REPLACEMENT	_____ HEART ATTACK
_____ SEXUALLY TRANSMITTED DISEASE	_____ MALIGNANCIES
_____ LOW BLOOD PRESSURE	_____ HEPATITIS
_____ AIDS/HIV	_____ HEART MURMUR
_____ RADIATION TREATMENT	_____ ABNORMAL BLEEDING
_____ ANEMIA	_____ ARTHRITIS
_____ MENTAL ILLNESS	_____ USED TOBACCO
_____ EMPHYSEMA	_____ SEIZURES
_____ DIABETES	_____ HEART VALVE PROBLEMS
_____ THYROID PROBLEMS	_____ SCARLET FEVER
_____ RHEUMATIC FEVER	_____ CHEMOTHERAPY
_____ ASTHMA	_____ HEART DISEASE
_____ CIRCULATORY PROBLEMS	_____ TYPHOID FEVER
_____ SINUS PROBLEMS	_____ ARE YOU IN RECOVERY?
_____ DO YOU USE RECREATIONAL DRUGS?	_____ STROKE
	_____ OTHER
_____ TUBERCULOSIS: _____ ACTIVE?	_____
_____ DATE OF LAST NEGATIVE "ACID TEST"	_____
_____ CURRENTLY HAVE A COUGH?	_____

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