Medical History

Last Name: _____ First Name:_____
Birthdate:_____ Physician's name: _____
Physician's address: _____ Phone #: _____

Please Circle **Yes** or **No** for the following: *(If yes, please fill in the details)*

HAVE YOU HAD ANY…

Yes No Major illnesses? What? _____
Yes No Operations? What kind & date: _____
Yes No Serious accidents? What kind & date: _____
Yes No Have you seen a physician within the last 12 months? _____
Yes No Are you currently taking any medication?

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND WHY: *(Supply list to front desk)*

_____ _____
_____ _____
_____ _____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: *(PLEASE CHECK)*

- ❑ Abnormal bleeding/Anemia
- ❑ Allergies
- ❑ Arthritis
- ❑ Artificial Bones/Joints
- ❑ Asthma or Hay Fever
- ❑ Bone Disorders
- ❑ Congenital Heart Defect
- ❑ Hepatitis/Liver Problems
- ❑ Diabetes
- ❑ Difficulty Breathing/Lung Issues
- ❑ Dizziness/Fainting
- ❑ Drug/Alcohol Use
- ❑ Epilepsy/Seizures
- ❑ Fever Blisters
- ❑ Gastrointestinal Disorders
- ❑ Headaches/Migraines
- ❑ Heart Problems/Surgery
- ❑ Heart Murmur/Mitral Valve Prolapse
- ❑ Heart Attack
- ❑ Hemophilia
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ HIV+/Aids
- ❑ Kidney problems
- ❑ Low Blood Pressure
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Pregnant/Nursing
- ❑ Psychiatric Disorders
- ❑ Prolonged Bleeding
- ❑ Radiation/Chemotherapy
- ❑ Rheumatic Fever
- ❑ Shingles
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Surgery w Metal/Screws
- ❑ Tuberculosis
- ❑ Tumor or Cancer
- ❑ NONE OF THE ABOVE

LIST ANY SURGERY OR MEDICAL CONDITIONS THAT WE SHOULD KNOW ABOUT:

_____

ANY ADVERSE REACTIONS TO ANY OF THE FOLLOWING (*CIRCLE ALL THAT APPLY)*:

Penicillin Erythromycin Codeine Aspirin Novacaine Latex
Tetracycline Other: _____

Signature: _____ Date: _____