Medical History for _____

(Patient Name)

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____ Phone: _____

Date of last visit: _____

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

Please explain: _____

Do you use tobacco in any form? ❑ Yes ❑ No

Have you had any metal rods, pins or implants placed? ❑ Yes ❑ No

Are you taking any medications? ❑ Yes ❑ No

Please list each one: _____

_____

Have you ever had any surgical procedures? ❑ Yes ❑ No

Please list each one: _____

Yes	No	Conditions
❑	❑	Abnormal Bleeding
❑	❑	Alcohol Abuse
❑	❑	Allergies
❑	❑	Anemia
❑	❑	Angina Pectoris
❑	❑	Arthritis
❑	❑	Artificial Heart Valve
❑	❑	Asthma
❑	❑	Blood Transfusion
❑	❑	Cancer
❑	❑	Chemotherapy
❑	❑	Colitis
❑	❑	Congenital Heart Defect
❑	❑	Diabetes
❑	❑	Difficulty Breathing
❑	❑	Drug Abuse
❑	❑	Emphysema
❑	❑	Epilepsy
❑	❑	Facial Surgery
❑	❑	Fainting Spells
❑	❑	Fever Blisters
❑	❑	Frequent Headaches

Yes	No	Conditions
❑	❑	Glaucoma
❑	❑	HIV+ AIDS
❑	❑	Heart Attack
❑	❑	Heart Murmur
❑	❑	Heart Surgery
❑	❑	Hemophilia
❑	❑	Hepatitis A
❑	❑	Hepatitis B
❑	❑	Hepatitis C
❑	❑	High Blood Pressure
❑	❑	Joint Replacement
❑	❑	Kidney Problems
❑	❑	Liver Disease
❑	❑	Low Blood Pressure
❑	❑	Mitral Valve Prolapse
❑	❑	Pace Maker
❑	❑	Psychiatric Problems
❑	❑	Radiation Therapy
❑	❑	Rheumatic Fever
❑	❑	Seizures
❑	❑	Sexually Transmitted Disease
❑	❑	Shingles

Yes	No	Conditions
❑	❑	Sickle Cell Disease
❑	❑	Sinus Problems
❑	❑	Stroke
❑	❑	Thyroid Problems
❑	❑	Tuberculosis
❑	❑	Ulcers

Yes	No	Not sure	Allergies
❑	❑	❑	Aspirin
❑	❑	❑	Codeine
❑	❑	❑	Erythromycin
❑	❑	❑	Sulfa
❑	❑	❑	Latex
❑	❑	❑	Metals
❑	❑	❑	Penicillin
❑	❑	❑	Tetracycline

Other: _____

For Female

Yes	No	
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant?

If yes, # of weeks _____

❑ ❑ Are you nursing?

Emergency Contact : _____ Phone #: _____ Relationship: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____