

# Medical History

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Y	N		Y	N		Y	N	
_____	_____	Abnormal Bleeding	_____	_____	Glaucoma	_____	_____	Sinus Problems
_____	_____	Alcohol Abuse	_____	_____	Hay Fever	_____	_____	Stroke
_____	_____	Allergies	_____	_____	Heart Attack	_____	_____	Thyroid Problems
_____	_____	Anemia	_____	_____	Heart Surgery	_____	_____	Tuberculosis
_____	_____	Angina Pectoris	_____	_____	Hemophilia	_____	_____	Ulcers
_____	_____	Arthritis	_____	_____	Hepatitis A	_____	_____	Venereal Disease
_____	_____	Artificial Bones	_____	_____	Hepatitis B	_____	_____	Yellow Jaundice
_____	_____	Artificial Heart Valves	_____	_____	Hepatitis C	_____	_____	Smoke/Use Tobacco
_____	_____	Asthma	_____	_____	High Blood Pressure			<b>Female Information</b>
_____	_____	Blood Transfusion	_____	_____	HIV & AIDS	_____	_____	Birth Control
_____	_____	Cancer Chemotherapy	_____	_____	Kidney Problems	_____	_____	Pregnant
_____	_____	Colitis	_____	_____	Liver Disease	_____	_____	Nursing
_____	_____	Congenital Heart Defect	_____	_____	Low Blood Pressure			<b>Allergies</b>
_____	_____	Cosmetic Surgery	_____	_____	Mitral Valve Prolapse	_____	_____	Aspirin
_____	_____	Diabetes	_____	_____	Pace Maker	_____	_____	Codeine
_____	_____	Difficulty Breathing	_____	_____	Pneumocystitis	_____	_____	Dental Anesthetics
_____	_____	Drug Abuse	_____	_____	Psychiatric Problems	_____	_____	Erythromycin
_____	_____	Emphysema	_____	_____	Radiation Therapy	_____	_____	Jewelry
_____	_____	Epilepsy	_____	_____	Rheumatic Fever	_____	_____	Latex
_____	_____	Fainting Spells	_____	_____	Seizure	_____	_____	Metals
_____	_____	Fever Blisters	_____	_____	Shingles	_____	_____	Penicillin
_____	_____	Frequent Headaches	_____	_____	Sickle Cell Disease	_____	_____	Tetracycline

Other:

\_\_\_\_\_

\_\_\_\_\_

Are you currently taking any medications (including aspirin) ? If yes please list:

\_\_\_\_\_

\_\_\_\_\_

Is there any disease, condition or problem that you think this office should know about that is not covered above?

If yes please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent or Guardian if under 18)