MEDICAL HISTORY

Name _____

Address _____

City _____

State _____ Zip _____

Phone: home: _____ office: _____ cell: _____

Soc.Sec.No. _____

Date of birth _____

Email Address _____

Name of physician _____

Address _____

City _____

State _____ Zip _____

Date of last physical exam _____

In case of emergency notify _____

Phone _____ Relationship _____

Do you have any history of:	Yes	No
Anemia		
Angina		
Arthritis		
Asthma		
Blood disease		
Blood pressure (high)		
Blood pressure (low)		
Blood transfusion		
Bruise easily		
Cancer		
Cardiac pacemaker		
Chemotherapy		
Chest pains		
Diabetes		
Easily winded		
Emphysema		
Epilepsy/Convulsions		
Excessive bleeding		
Fainting/Seizures		
Frequently tired		
Glaucoma		
Hay fever/Allergies		
Heart attack		
Heart disease		

Do you have any history of:	Yes	No
Heart murmur		
Heart trouble		
Heart valve problems		
Hepatitis/Jaundice		
HIV or AIDS		
Joint replacement or implant		
Kidney/Bladder trouble		
Leukemia		
Liver disease		
Lung disease		
Mental disorders		
Parkinson's Disease		
Prolonged bleeding		
Radiation treatment		
Recent weight loss		
Respiratory problems		
Rheumatic fever		
Sexually transmitted disease		
Sinus trouble		
Stomach troubles/Ulcers		
Stroke		
Swollen ankles		
Thyroid problems		
Tuberculosis		
Other		

	Yes	No
Are you under medical treatment now?		
Explain:		
Have you ever been hospitalized for any operation or serious illness?		
Explain:		
Do you drink alcohol?		
If yes: How much?		
Do you use cocaine or other drugs?		
Do you use tobacco?		
Are you wearing contact lenses?		

Are you allergic to or have you had any reactions to the following?	Yes	No
Local anesthetics (ex: novocaine)		
Penicillin or other antibiotics		
Sulfa Drugs		
Barbiturates		
Sedatives		
Iodine		
Aspirin		
Codeine		
Other		

Check any of the following that you are taking or have taken:

____ Cortisone drugs/steroids _____ Anticoagulants/blood thinners _____Tranquilizers/sedatives

Check if you have ever been given:

_____ Novocaine _____ Penicillin _____ Erythromycin _____ Codeine _____ Fluoride supplement/rinse

List any medications you are taking _____

_____

_____

Women only:	Yes	No
Are you or think you may be pregnant?		
If yes : How many months		
Are you breast feeding?		

	Yes	No
Are you taking any hormone therapy?		
Are you taking any birth control pills/shots?		

Authorization and Release

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.
I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of patient or parent if minor *Date*

_____

Doctor's signature *Date*

Comments _____