Medical History

Patient Name

Nickname

Age

Name of Physician

Phone #

Most recent physical examination

Purpose

If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.
Have you had any of the following diseases or problems?

Active Tuberculosis ○ **Yes** ○ **No**
Persistent cough greater than a 3 week duration
Cough that produces blood

What is your estimate of your general health?

○ Poor ○ Fair ○ Good

Has there been any change in your general health within the past year?

What medicines are you taking?

Prescribed:

Over the counter:

Vitamins, natural or herbal preparation and/or diet supplements:

Answer yes or no to the following questions:

Have you had an allergic reaction to		
aspirin, ibuprofen,	○ **Yes**	○ **No**
penicillin or other antibiotic	○ **Yes**	○ **No**
codeine or other narcotic	○ **Yes**	○ **No**
local anesthetic	○ **Yes**	○ **No**
flouride	○ **Yes**	○ **No**
metals (gold, stainless steel)	○ **Yes**	○ **No**
latex	○ **Yes**	○ **No**

any other medications

Gastrointestinal disease	○ **Yes**	○ **No**
GE Reflux/persistent heartburn	○ **Yes**	○ **No**
Glaucoma	○ **Yes**	○ **No**
Head or neck injuries	○ **Yes**	○ **No**
Hemophilia	○ **Yes**	○ **No**
Hepatitis, jaundice or liver disease	○ **Yes**	○ **No**
Hives, skin rash, hay fever	○ **Yes**	○ **No**
History of tobacco use (eg cigs, cigars,	○ **Yes**	○ **No**
smokeless)	○ **Yes**	○ **No**
Recurrent infections	○ **Yes**	○ **No**
Kidney problems	○ **Yes**	○ **No**
Mental health disorders	○ **Yes**	○ **No**

if yes specify

Have you ever had the following

Condition	Yes	No
Abnormal bleeding	○ Yes	○ No
AIDS or HIV infection	○ Yes	○ No
Anemia	○ Yes	○ No
Arthritis (or Rheumatoid arthritis)	○ Yes	○ No
Artificial prosthesis (heart valve or joints) If yes, date	○ Yes	○ No
Asthma	○ Yes	○ No
Blood transfusion, if yes what date?	○ Yes	○ No
Cancer/Chemotherapy/Radiation Treatment	○ Yes	○ No
Cardiovascular disease, if yes specify below	○ Yes	○ No

- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Congenital heart defect
- ☐ Congestive heart failure
- ☐ Damaged heart valves
- ☐ Coronary artery disease
- ☐ Heart Attack
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Rheumatic heart disease or fever

Condition	Yes	No
Chest Pain on exertion	○ Yes	○ No
Chronic pain	○ Yes	○ No
Disease, drug, or radiation-induced immunosuppression	○ Yes	○ No
Diabetes	○ Yes	○ No
Type I insulin dependent	○ Yes	○ No
Type II	○ Yes	○ No
Eating disorder or malnutrition	○ Yes	○ No
Emphysema, bronchitis or COPD	○ Yes	○ No
Epilepsy, convulsions (seizures)	○ Yes	○ No
Fainting spells or seizures	○ Yes	○ No
Migraines or severe headaches	○ Yes	○ No
Night sweats	○ Yes	○ No
Neurological disorders If yes specify	○ Yes	○ No
Osteoporosis	○ Yes	○ No
Persistent swollen glands of neck	○ Yes	○ No
Sinus trouble	○ Yes	○ No
Sleep disorder	○ Yes	○ No
Sores or ulcers in the mouth	○ Yes	○ No
Stroke	○ Yes	○ No
Systemic lupus	○ Yes	○ No
Thyroid problems	○ Yes	○ No
Tumor, abnormal growth	○ Yes	○ No
Ulcers	○ Yes	○ No
Excessive urination	○ Yes	○ No
Viral infections and cold sores	○ Yes	○ No
Other condition we should be aware of	○ Yes	○ No

WOMEN ONLY

Question	Yes	No
Are you or could you be pregnant?	○ Yes	○ No
Nursing?	○ Yes	○ No
Taking birth control pills or hormonal replacement?	○ Yes	○ No

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________________ **Date** ______________

Doctor's Remarks ______________________________ **Date** ______________

Doctor's Signature ______________________________ **Date** ______________