PATIENT MEDICAL HISTORY

PATIENT NAME:_____ TODAY'S DATE:_____ SEX:_____

ADDRESS:_____ CITY, STATE, ZIP:_____

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____

BIRTH DATE:_____ SSN:_____ EMAIL:_____

PLACE OF EMPLOYMENT:_____ OCCUPATION:_____

PHYSICIAN NAME:_____ PHARMACY:_____

INSURANCE POLICY HOLDER:_____ SSN:_____ DOB:_____

INSURANCE COMPANY:_____ POLICY HOLDER PHONE:_____

PLEASE ANSWER THE FOLOWING: ☐ Y ☐ N DO YOU SMOKE OR USE TOBACCO?

IF FEMALE, PLEASE ANSWER THE FOLLOWING: ☐ Y ☐ N ARE YOU TAKING BIRTH CONTROL?

☐ Y ☐ N ARE YOU PREGNANT? IF YES, # OF WEEKS?_____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS:

Y	N		Y	N		Y	N	
☐	☐	ABNORMAL BLEEDING	☐	☐	HEART ATTACK	☐	☐	ASPIRIN
☐	☐	ALLERGIES	☐	☐	HEART STENT	☐	☐	CODEINE
☐	☐	ANEMIA	☐	☐	HEART SURGERY	☐	☐	DENTAL ANESTHETICS
☐	☐	ANGINA PECTORIS	☐	☐	HEMOPHILIA	☐	☐	ERYTHROMYCIN
☐	☐	ARTHRITIS	☐	☐	HEPATITIS A	☐	☐	JEWELERY
☐	☐	ARTIFICIAL HEART VALVE	☐	☐	HEPATITIS B	☐	☐	LATEX
☐	☐	ARTIFICIAL JOINTS	☐	☐	HEPATITIS C	☐	☐	METALS
☐	☐	ASTHMA	☐	☐	HIGH BLOOD PRESSURE	☐	☐	PENICILLIN
☐	☐	BISPHOSPHATES (BONE MEDS)	☐	☐	KIDNEY PROBLEMS	☐	☐	TETRACYCLINE
☐	☐	BLOOD THINNERS	☐	☐	LIVER DISEASE			
☐	☐	CANCER (CHEMOTHERAPY)	☐	☐	LOW BLOOD PRESSURE	OTHER:		
☐	☐	CONGENITAL HEART DEFECT	☐	☐	MITRAL VALVE PROLAPSE			
☐	☐	DIABETES	☐	☐	PACE MAKER			
☐	☐	DIFFICULTY BREATHING	☐	☐	PREMEDICATE			
☐	☐	DRUG ABUSE	☐	☐	RADIATION THERAPY			
☐	☐	EMPHYSEMA	☐	☐	RECENT SURGERY			
☐	☐	EPILEPSY	☐	☐	SEIZURES			
☐	☐	FAINTING SPELLS	☐	☐	STROKE			
☐	☐	FEVER BLISTERS	☐	☐	THYROID PROBLEMS			
☐	☐	HIV + AIDS	☐	☐	TUBERCULOSIS			
☐	☐	HEAD INJURY	☐	☐	ULCERS			

IS THERE ANY DISEASE, CONDITION, OR PROBLEM THAT YOU THINK THIS OFFICE SHOULD KNOW ABOUT THAT IS NOT COVERED ABOVE? IF YES, PLEASE DESCRIBE BELOW....

PLEASE EXPLAIN ANY RECENT SURGERIES AND INCLUDE THE DATE OF SURGERY ....

MEDICATIONS:

NOTES:

SIGNATURE:_____ DATE:_____

IF UNDER 18, PARENT OR GUARDIAN SIGNATURE REQUIRED)