

# MEDICAL HISTORY

Physician: \_\_\_\_\_

Physician Phone Number: \_\_\_\_\_

Have you ever been hospitalized for any surgical operation or serious illness? (if yes please describe) \_\_\_\_\_

Do you take Aspirin daily? \_\_\_\_\_

Do you use tobacco? \_\_\_\_\_

## HEALTH CONDITIONS *(Check all that apply)*

- Anemia
- Angina
- Arthritis, Rheumatism
- Artificial Heart Valves
- Artificial Joints/Hips/Pins/Plates
- Asthma
- Back Problems
- Blood Disease
- Cancer
- Cardiac Pacemaker
- Chemical Dependency
- Chemotherapy
- Circulatory Problems
- Congenital Heart Lesions
- Cortisone Treatments
- Diabetes
- Emphysema
- Epilepsy
- Fainting / Seizures

- Glaucoma
- Headaches
- Heart Attack
- Heart Disease
- Heart Murmur
- Hepatitis Type \_\_\_\_\_
- High Blood Pressure
- Jaundice
- Kidney Disease
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Nervous Problems
- Psychiatric Care
- Radiation Treatment
- Respiratory Disease
- Rheumatic Fever
- Scarlet Fever
- Shortness of Breath

- Sinus Trouble
- Special Diet
- Stroke
- Swollen Neck Glands
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Tumor on head or neck
- Ulcer
- Venereal Disease
- Unexplained Weight Loss
- Other – Please explain

*Are you allergic to or have you had any reactions to the following:*

- Local Anesthetics
- Penicillin / Antibiotics
- Sulfa Drugs
- Barbituates
- Sedatives
- Iodine
- Aspirin
- Other (Please List): \_\_\_\_\_

### Women Only:

- Are you pregnant or think you may be pregnant?
- Are you nursing?
- Are you taking Birth Control Pills?

### CURRENT MEDICATIONS:

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

*Thank you for answering these questions to the best of your knowledge*

## Below for Office Use Only

### Health Updates:

Date: _____	
HEALTH CHANGES	CURRENT MEDICATIONS
	1. _____
	2. _____
	3. _____
	4. _____
	5. _____
	6. _____

Patient's Signature: \_\_\_\_\_ Staff Initials: \_\_\_\_\_

Date: _____	
HEALTH CHANGES	CURRENT MEDICATIONS
	1. _____
	2. _____
	3. _____
	4. _____
	5. _____
	6. _____

Patient's Signature: \_\_\_\_\_ Staff Initials: \_\_\_\_\_