

PATIENT MEDICAL HISTORY

Date of Birth: ____/____/____

Are you under the care of a physician? _____ Date of last physical exam: _____

Physician's Name: _____ Physician's Phone #: _____

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

If so, what is the condition being treated? _____

Please list any prescription or non-prescription medications: _____

Please list any known allergies (such as Penicillin, Latex, Codeine, etc.): _____

Do you smoke or use tobacco products? _____

HEALTH HISTORY

Please check any of the following that apply...

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joints | <input type="checkbox"/> | <input type="checkbox"/> | HIV+/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve | <input type="checkbox"/> | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing | <input type="checkbox"/> | <input type="checkbox"/> | Yellow Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | | | |

- Yes No
 Do you have any disease, condition, or problem not listed above that you think we should know about? If yes, please explain: _____

For Women Only...

- Yes No
 Are you taking Birth Control Pills?
 Are you pregnant? # of weeks: _____
 Are you nursing?

Signature: _____

Date: _____

