

PATIENT MEDICAL HISTORY

Patient Name: _____ 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

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

Yes No
 Do you have any disease, condition/ additional details, 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: _____

