

## MEDICAL HISTORY

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

Do you have a personal physician?  Yes  No Your current physical health is:  Good  Fair  Poor

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

Do you use tobacco in any form?  Yes  No Have you had any metal rods, pins or implants placed?  Yes  No

Are you taking any medications?  Yes  No

Please list each one: \_\_\_\_\_

Have you ever had any surgical procedures?  Yes  No

Please list each one: \_\_\_\_\_

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions																														
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease																														
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	HIV + AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems																														
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Stroke																														
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems																														
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis																														
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers																														
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<table border="0"> <thead> <tr> <th>Yes</th> <th>No</th> <th>Allergies</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Aspirin</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Codeine</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Dental Anesthetics</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Erythromycin</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Jewelry</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Latex</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Metals</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Penicillin</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Tetracycline</td> </tr> </tbody> </table>			Yes	No	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	Jewelry	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	Metals	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
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<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C																																	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure																																	
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement																																	
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems																																	
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease																																	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure																																	
<input type="checkbox"/>	<input type="checkbox"/>	Difficult Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse																																	
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker																																	
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems																																	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy																																	
<input type="checkbox"/>	<input type="checkbox"/>	Facial Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever																																	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Seizures																																	
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease																																	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Shingles																																	

Nearest relative not living with you:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_