PATIENT MEDICAL HISTORY

Name: **Date Of Birth:**

Today's Date:

For office use only

Medical Alerts:

Physician Name: Phone:

Sex: M F

Y N Are you taking Birth Control Pills?

Y N Are you pregnant? If so, # of weeks

Y N Are you nursing?

Y N Do you smoke or use Tobacco

Height: **Weight:**

Y N	**Conditions:**
□ □	Abnormal bleeding
□ □	Alcohol Abuse
□ □	Allergies
□ □	Anemia
□ □	Angina Pectoris
□ □	Arthritis
□ □	Artificial Bones
□ □	Artificial Heart Valve
□ □	Asthma
□ □	Blood Transfusion
□ □	Cancer-Chemotherapy
□ □	Colitis
□ □	Congenital Heart Defect
□ □	Cosmetic Surgery
□ □	Diabetes
□ □	Difficulty Breathing
□ □	Drug Abuse
□ □	Emphysema
□ □	Epilepsy
□ □	Fainting Spells
□ □	Fever Blisters
□ □	Frequent Headaches

Y N	**Conditions:**
□ □	Glaucoma
□ □	Hay Fever
□ □	Heart Attack
□ □	Heart Surgery
□ □	Hemophilia
□ □	Hepatitis A
□ □	Hepatitis B
□ □	High Blood Pressure
□ □	HIV+ AIDS
□ □	Kidney Problems
□ □	Liver Disease
□ □	Low Blood Pressure
□ □	Mitral Valve Prolapse
□ □	Pace Maker
□ □	Pneumocystitis
□ □	Psychiatric Problems
□ □	Radiation Therapy
□ □	Rheumatic Fever
□ □	Seizures
□ □	Shingles
□ □	Sickle Cell Disease
□ □	Sinus Problems

Y N	**Conditions:**
□ □	Stroke
□ □	Thyroid Problems
□ □	Tuberculosis
□ □	Ulcers
□ □	Venereal Disease
□ □	Yellow Jaundice

Y N	**Allergies**:
□ □	Aspirin
□ □	Codeine
□ □	Dental Anesthetics
□ □	Erythromycin
□ □	Jewelry
□ □	Latex
□ □	Metals
□ □	Penicillin
□ □	Tetracycline

Other: _____

_____

_____

Medications:

Y N

☐ ☐ **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...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)