

# PATIENT MEDICAL HISTORY

## Patient's Medical History

### Physician Information

Physician's Full Name: \_\_\_\_\_

City, State and ZIP: \_\_\_\_\_

Are you currently under a physician's Care?  Yes  No

If Yes, for what?

Have you been hospitalized in the last two years?  Yes  No

If Yes, for what?

Are you taking any medication, drugs or pills?  Yes  No

If so, please list the names and dosages of each:

Do you Smoke?  Yes  No How Much? \_\_\_\_\_

### Women Only

Are you pregnant?  Yes  No Are you taking birth control pills?  Yes  No

Are you nursing?  Yes  No Are you on Hormone Therapy?  Yes  No

## Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

### Medical Alerts

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Allergic to Penicillin   | <input type="checkbox"/> Allergic to Codeine      | <input type="checkbox"/> Pre-Medication required | <input type="checkbox"/> Pacemaker       |
| <input type="checkbox"/> Allergic to Tetracycline | <input type="checkbox"/> Allergic to 'Novocaine'  | <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> HIV Positive    |
| <input type="checkbox"/> Allergic to Aspirin      | <input type="checkbox"/> Allergic to Latex Rubber | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Prior Hepatitis |

Other

### Medical Conditions

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Excessive Bleeding when Cut | <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Swelling of Feet/Ankles      |
| <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Sickle Cell Disease         | <input type="checkbox"/> Ulcers                 | <input type="checkbox"/> Artificial Joint Replacement |
| <input type="checkbox"/> Chest Pain               | <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Gastrointestinal Upset | <input type="checkbox"/> Psychiatric Care             |
| <input type="checkbox"/> Congenital Heart Problem | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Acid Reflux            | <input type="checkbox"/> Epilepsy or Seizures         |
| <input type="checkbox"/> Artificial Heart Valve   | <input type="checkbox"/> Excessive Thirst            | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Extreme Nervousness          |
| <input type="checkbox"/> Heart Surgery            | <input type="checkbox"/> Scarlet Fever               | <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Fainting or Dizziness        |
| <input type="checkbox"/> High/Low Blood Pressure  | <input type="checkbox"/> Thyroid Disease             | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Hypoglycemia                 |
| <input type="checkbox"/> Rheumatic Fever          | <input type="checkbox"/> Parathyroid Disease         | <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Hives                        |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Cold Sores/Fever Blisters    |
| <input type="checkbox"/> Blood Disease            | <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> Sinus Trouble          | <input type="checkbox"/> Venereal Disease             |
| <input type="checkbox"/> Blood Transfusion        | <input type="checkbox"/> Hepatitis A or B            | <input type="checkbox"/> Hay Fever              | <input type="checkbox"/> Herpes                       |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Yellow Jaundice             | <input type="checkbox"/> Frequent Cough         | <input type="checkbox"/> Cortisone Treatment          |
| <input type="checkbox"/> Deep Vein Clot           | <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Rheumatism             | <input type="checkbox"/> Chemical Dependency          |
| <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> X-Ray or Cobalt Treatment   | <input type="checkbox"/> Arthritis/Gout         |   |