PATIENT MEDICAL HISTORY

Patient's Name:	Marital Status:	Birth Date:

Address:	City, State, Zip

Home Phone:	Work Phone:	Cell Phone:	Email:

Physician Name:	Physician Phone/City: (if available)

Pharmacy:	Pharmacy Phone:

Sex: ☐

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?

For Office Use Only

BP: ☐ Heart Rate: ☐

Height: ☐

Weight: ☐

Y	N	Conditions
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arrhythmia
☐	☐	Arthritis
☐	☐	Artificial Bones/Joints
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Bleeding Problems
☐	☐	Blood Transfusion
☐	☐	COPD
☐	☐	Cold Sores (Herpes)
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Coronary Artery Bypass Graft (CAB
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug/Alcohol Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	Glaucoma

Y	N	Conditions
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hepatitis/Jaundice (Liver Disease)
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	History Of Cancer
☐	☐	History Of Endocarditis
☐	☐	History Of Mental Illness
☐	☐	History Of Seizures
☐	☐	Hormonal Supplements
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Osteoporosis
☐	☐	Osteoporosis Medication
☐	☐	Pace Maker
☐	☐	Prostate Disorders
☐	☐	Prosthetic Heart Valves
☐	☐	Radiation/Chemotherapy
☐	☐	Rheumatic Fever

Y	N	Conditions
☐	☐	Sexually Transmitted Disease
☐	☐	Sleep Apnea
☐	☐	Stomach Ulcers
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Is there any disease, condition, or problem that you think this office should know about that is not covered on these forms? If so, please explain below.

_____

_____

Patient Signature: _____ Date: _____