MEDICAL HISTORY FORM

Patient's Last Name ________________________________ Middle Initial ______ First Name

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

For what reason: ____

When was your last physical exam? ____

Physician's Name ____

Address _____________________________________ Phone ______________ Last Time Seen ______

Have you ever been hospitalized? □ No □ Yes

If yes, please explain____

Are you taking any prescription medication? □ No □ Yes

If yes, please explain____

Are you taking any over the counter medication? □ No □ Yes

If yes, please explain____

Do you have any allergies? □ No I Yes

If yes, please explain____

Are you allergic to any medications or substances? □ No □ Yes

If yes, please explain____

Do you have any problems with antibiotics or anesthetics? □ No □ Yes

If yes, please explain____

Do you take appetite suppressants? □ No □ Yes Name of product

Have you ever had any of the following diseases or medical conditions?

□ No	□ Yes	Heart Attack/Stroke	□ No	□ Yes	Epilepsy
□ No	□ Yes	Cancer/Chemotherapy	□ No	□ Yes	Seizures
□ No	□ Yes	Heart Murmur	□ No	□ Yes	Fainting
□ No	□ Yes	Rheumatic Fever	□ No	□ Yes	Diabetes
□ No	□ Yes	HIV/AIDS	□ No	□ Yes	Tuberculosis
□ No	□ Yes	Hepatitis A	□ No	□ Yes	Hemophilia
□ No	□ Yes	Hepatitis B	□ No	□ Yes	Blood Transfusion
□ No	□ Yes	Hepatitis C	□ No	□ Yes	High Blood Pressure
□ No	□ Yes	Hepatitis D	□ No	□ Yes	Low Blood Pressure
□ No	□ Yes	Anemia	□ No	□ Yes	Radiation Treatment
□ No	□ Yes	Mitral Valve Prolapse	□ No	□ Yes	Kidney Problems
□ No	□ Yes	Artificial Bones/Joints	□ No	□ Yes	Artificial Valves
□ No	□ Yes	Sinus Problems	□ No	□ Yes	Severe Headaches
□ No	□ Yes	Asthma	□ No	□ Yes	Frequent Headaches
□ No	□ Yes	Difficulty Breathing	□ No	□ Yes	Emphysema
□ No	□ Yes	Venereal Disease	□ No	□ Yes	Shingles
□ No	□ Yes	Herpes Type I	□ No	□ Yes	Herpes Type II
□ No	□ Yes	Heart Surgery	□ No	□ Yes	Pace Maker
□ No	□ Yes	Psychiatric Problems	□ No	□ Yes	Glaucoma
□ No	□ Yes	Do You Smoke?	□ No	□ Yes	Do You Consume Alcohol?

Are You Allergic To Any Of The Following?

□ No	□ Yes	Penicillin	□ No	□ Yes	Codeine
□ No	□ Yes	Aspirin	□ No	□ Yes	Tetracycline
□ No	□ Yes	Erythromycin	□ No	□ Yes	Germicides/Pesticides
□ No	□ Yes	Latex/or Rubber Products	□ No	□ Yes	Other _________________

For Women Only:

□ No	□ Yes	Taking Birth Control Pills	□ No	□ Yes	Pregnant/No. of Months ___
□ No	□ Yes	Nursing?	□ No	□ Yes	Hormone Therapy

Signature ____ Date ________________________

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