Medical History

Name: _____ Date: _____

Do you have a personal physician? □ Yes □ No
Physician's Name: _____
Physician's Phone: _____
Date of Last Visit: _____
Your current physical health is: □ Good □ Fair □ Poor
Are you currently under the care of a physician? □ Yes □ No
Please explain: _____
Pharmacy: _____ Phone: _____

Do you use tobacco in any form? □ Yes □ No
Have you had any metal rods, pins or artificial joints placed? □ Yes □ No
Have you had any surgical procedures? □ Yes □ No
Please list each one: _____

Do you require PREMEDICATION? □ Yes □ No

Yes	No	Conditions	Yes	No	Conditions
□	□	Abnormal Bleeding	□	□	Heart Attack
□	□	Alcohol/Drug Abuse	□	□	Heart Murmur
□	□	Allergies	□	□	Heart Surgery
□	□	Alzheimer's/Dementia	□	□	Hemophilia
□	□	Anemia	□	□	Hepatitis A
□	□	Angina Pectoris	□	□	Hepatitis B
□	□	Arthritis	□	□	Hepatitis C
□	□	Artificial Heart Valve	□	□	High Blood Pressure
□	□	Asthma	□	□	Joint Replacement
□	□	Atrial Fibrillation (AFIB)	□	□	Kidney Problems
□	□	Autism	□	□	Liver Disease
□	□	Back/Neck Problems or Surgery	□	□	Low Blood Pressure
□	□	Blood Transfusions	□	□	Mitral Valve Prolapse
□	□	Cancer	□	□	Pace Maker
□	□	Chemotherapy	□	□	Parkinson's disease
□	□	Colitis	□	□	Psychiatric Problems
□	□	Congenital Heart Defect	□	□	Radiation Therapy
□	□	Depression or Anxiety	□	□	Seizures
□	□	Diabetes	□	□	Sexually Transmitted Disease
□	□	Difficulty Breathing	□	□	Shingles
□	□	Emphysema	□	□	Sickle Cell Disease
□	□	Epilepsy	□	□	Sinus Problems
□	□	Facial Surgery	□	□	Stroke
□	□	Fainting Spells	□	□	Thyroid Problems
□	□	Frequent Headaches	□	□	Tuberculosis
□	□	Glaucoma	□	□	Ulcers
□	□	HIV + AIDS			

Yes	No	**Allergies**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other Allergies: _____

Please list all medications or vitamins you are taking:

Please list any other medical condition or other issues you feel we should be aware of:

Yes	No	**If Female Please Answer**
☐	☐	Are you taking birth control pills?
☐	☐	Are you pregnant?
		If so, # of weeks _____
☐	☐	Are you nursing?

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____ Phone: _____

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

Signature: _____ Date: _____

Print name:_____