|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PATIENT MEDICAL HISTORY** |  |  |  | TODAY’S DATE |
| Patient’s Name | Age | Birthdate |
| Patient’s Address | City | State | Zip |
| Social Security # | Home # |  | Work # |  | Cell # |  |
| Weight | Height | Race | Sex | Email Address |
| Name of Insurance |  |  | Relation to insured |
| Insured’s Name | Insured’s SS # | Insured’s DOB |
| Insured’s Employer | Spouse’s Name |
| Physician’s Name & Contact # | Spouse’s Work | Spouse’s Cell |
| Person to notify in an emergency | Emergency Contact # |
| Where would you like us to contact you regarding your appointments? Home Work Cell Email All | Driver’s License Number/State |

**MEDICAL HISTORY**

**Please Circle Yes (Y) or No (N) after the following questions:**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Has there been any change in your general health during the past year? | Y N | 7. Have you ever been hospitalized Reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y N |
| 2. Are you under a physician’s care other than for routine physicals? | Y N | 8. Women: Are you pregnant | Y N |
| 3. Date of last physical \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | 9. Do you have any other condition that may affect your treatment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4. Have you had any serious illness or operations?  | Y N | 10. Do you smoke?How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y N |
| 5. Do you have, or have you had: a. Rheumatic fever or rheumatic heart disease b. Heart murmur or Mitro Valve Prolapse c. Cardiovascular Disease (heart trouble) coronary artery disease, angina, stroke? d. High blood pressure? e. Hay fever? f. Sinus trouble? g. Asthma? h. Hepatitis, jaundice, liver disease? i. Arthritis? j. Fainting spells or seizures (Epilepsy)? k. Diabetes? l. Ulcers? m. Kidney or bladder disease? n. Low blood pressure? o. Thyroid condition? p. Anemia or other blood disorder? q. cancer, chemotherapy, or radiation? r. Artificial joint/implants? s. Emphysema? t. Tuberculosis? | Y NY NY NY NY NY NY NY NY NY NY NY NY NY NY NY NY NY NY NY N | 11. Are you allergic to or have you had an adverse reaction to: a. Antibiotics (penicillin, sulfa, tetracycline) b. Sedatives or tranquilizers? c. Aspirin? d. Codeine or other painkillers? e. Iodine? f. Other allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_12. Do you believe you may be immunosuppressed or HIV positive?13. Are you taking any medication that may affect your immune system?14. Do you have Glaucoma?15. Have you had a prolonged fever, coughing blood, or chest pain?16. Are you using any of the following? a. Antibiotics or sulfa drugs b. Anticoagulants (blood thinners)? c. High blood pressure medicines? d. Heart medications (Digitalis, Inderal, Nitroglycerin)? e. Steroids (Cortisone, etc)? f. Birth Control Pills? g. Insulin or diabetic drugs? | Y NY NY NY NY NY NY NY NY NY NY NY NY NY NY NY NY N |

\*List Medications or drugs you are currently taking below. Attach separate sheet if necessary

|  |  |  |
| --- | --- | --- |
| Medications | Indications | Side Effects |
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