PATIENT MEDICAL HISTORY

Patient's Name: | **Today's Date:**

Address: | **City:** | **State:** | **Zip:**

Email Address:

Home Phone:	Cell Phone:	Work Phone:	Birth Date:	Social Security No.:	Marital Status:

Medications:

Sex:

M F

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?

Height: Weight:

Please mark all that apply:

Conditions

- ☐ Heart (Surgery, Disease, Attack)
- ☐ Stroke
- ☐ Artificial Heart Valve
- ☐ Heart (Murmur,MVP,Pacemaker)
- ☐ Angina Pectoris
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Abnormal Bleeding
- ☐ Congenital Heart Defect
- ☐ Rheumatic Fever
- ☐ Blood Transfusion
- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ Diabetes HbA1c Score ________
- ☐ GERD/Reflux
- ☐ Artificial Joint Replacement
  Surgery Date ______________
- ☐ Hepatitis A B C
- ☐ Cold Sores/Herpes/Fever Blisters
- ☐ AIDS/HIV/ARC
- ☐ Veneral Diseases/STD/HPV
- ☐ Tuberculosis
- ☐ Asthma

Conditions

- ☐ Difficulty Breathing
- ☐ Seasonal Allergies
- ☐ Sinus Problems/Sinusitis
- ☐ Emphysema/COPD
- ☐ Arthritis
- ☐ Shingles
- ☐ Bone Replacement Therapy
- ☐ Fosamax, Boniva, Actonel, Zometa
- ☐ Autoimmune Disease Lupus Etc.
- ☐ Celiac, MS, RA, Crohns
- ☐ Cancer
- ☐ Radiation/Chemotherapy
- ☐ Epilepsy or Seizures
- ☐ High Cholesterol
- ☐ Glaucoma
- ☐ Colitis
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Alzheimers/Dementia

Conditions

- ☐ Drug or Alcohol Abuse
- ☐ Psychiatric Problems
- ☐ Nervousness/Anxiety/Depression
- ☐ Snoring or Sleep Apnea, CPAP
- ☐ Anything Not Listed Above

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Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline

Other: ______________________

PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST FOR UPDATES.