Medical History Update

Please update this form so that your medical history on file remains current. After completing this form, please sign below.

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease/Attack
Heart Murmur
Angina/Chest Pain
Congenital Heart Disorder
Mitral Valve Prolapse
Artificial Heart Valve
Heart Surgery
Heart Pacemaker
Rheumatic Fever
Anemia
Stroke
High/Low Blood Pressure
Blood Transfusion
Excessive Bleeding/Hemophilia
Bruises Easily
Sickle Cell Disease Hypoglycemia
Diabetes
Liver Diseases

Kidney Trouble
Renal Dialysis
Thyroid Disease
Arthritis
Pain in Jaw Joint/TMJ Disorder
Tuberculosis
Asthma
Emphysema
Epilepsy/Seizures Dizziness/Fainting
Cancer Chemotherapy
Radiation Therapy
Glaucoma Stomach
Problems/Ulcers
Artificial Joint/Prosthesis
AIDS
HIV Positive
Herpes

Venereal Disease
Hepatitis A, B, or C (Circle Type)
Fever Blisters/Cold Sores
Nervousness/Panic Attacks
Psychiatric Care
Alzheimer's Disease
Pregnant/Trying to Get Pregnant
Cortisone Medications
Smoker
Drug Addiction
Sinus Trouble
Codeine Allergy
Penicillin Allergy
List Other Allergies:

Have you ever had another serious illness not listed above?
_____
_____

Please list any medications/supplements you are currently on:
_____
_____

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By signing below, I acknowledge that all the preceding answers are correct and that I have updated my medical history by making any necessary changes. If I have any changes in my health status, or if my medications change. I will inform the staff at my next appointment, without fail.

Name: _____
Date: _____
Address: _____
_____
_____
Phone: _____
Signature: _____