

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

<p><b>YES</b>    <b>NO</b></p> <p>Are you in good health <input type="checkbox"/>    <input type="checkbox"/></p> <p>Have there been any changes in your general health within the past year <input type="checkbox"/>    <input type="checkbox"/></p> <p>Date of your last physical exam: _____</p> <p>Physician's Name _____</p> <p>Address _____</p> <p>Phone No. _____</p> <p>Are you now under the care of a physician <input type="checkbox"/>    <input type="checkbox"/></p> <p>Have you ever been hospitalized for any surgical operation or serious illness <input type="checkbox"/>    <input type="checkbox"/></p> <p>Please explain: _____</p> <p>Are you taking any medications, including non-prescription drugs? <input type="checkbox"/>    <input type="checkbox"/></p> <p><b>If yes, what medicine(s) are you taking</b> _____</p>	<p><b>YES</b>    <b>NO</b></p> <p>Have you had any abnormal bleeding <input type="checkbox"/>    <input type="checkbox"/></p> <p>Do you bruise easily <input type="checkbox"/>    <input type="checkbox"/></p> <p>Have you had a blood transfusion <input type="checkbox"/>    <input type="checkbox"/></p> <p>Have you had recent weight loss <input type="checkbox"/>    <input type="checkbox"/></p> <p>Have you ever taken fen-phen or redux <input type="checkbox"/>    <input type="checkbox"/></p> <p>Do you use tobacco <input type="checkbox"/>    <input type="checkbox"/></p> <p>Do you or have you used controlled substances <input type="checkbox"/>    <input type="checkbox"/></p> <p>Are you wearing contact lenses <input type="checkbox"/>    <input type="checkbox"/></p> <p>Do you have any disease, condition or problem you think I should know about <input type="checkbox"/>    <input type="checkbox"/></p> <p>Have you ever taken Bishosphonate <input type="checkbox"/>    <input type="checkbox"/></p> <p><b>COMMENTS</b> _____</p>
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<p><b>ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:</b></p> <p>Local anesthetics like novocaine <input type="checkbox"/>    <input type="checkbox"/></p> <p>Penicillin or other antibiotics <input type="checkbox"/>    <input type="checkbox"/></p> <p>Sulfa Drugs <input type="checkbox"/>    <input type="checkbox"/></p> <p>Barbiturates, sedatives or sleeping pills <input type="checkbox"/>    <input type="checkbox"/></p> <p>Aspirin <input type="checkbox"/>    <input type="checkbox"/></p> <p>Iodine <input type="checkbox"/>    <input type="checkbox"/></p> <p>Any metals (e.g., nickel, mercury, etc.) <input type="checkbox"/>    <input type="checkbox"/></p> <p>Latex/Rubber <input type="checkbox"/>    <input type="checkbox"/></p> <p>Other (please list) _____</p>	<p><b>WOMEN ONLY:</b></p> <p>Are you pregnant or think you may be pregnant <input type="checkbox"/>    <input type="checkbox"/></p> <p>Are you nursing <input type="checkbox"/>    <input type="checkbox"/></p> <p>Are you taking birth control pills <input type="checkbox"/>    <input type="checkbox"/></p> <p><b>COMMENTS</b> _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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<b>DO YOU OR HAVE YOU EVER HAD THE FOLLOWING:</b>								
	<b>Y</b>	<b>N</b>		<b>Y</b>	<b>N</b>		<b>Y</b>	<b>N</b>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cough that produces Blood	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Defect or Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble, Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Aids or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Fever	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Problem	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Care	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of feet, ankles, hands	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<b>COMMENTS</b> _____		
Lung or breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Asthma or Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____		
BP _____			Weight _____			Height _____		

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE OF PATIENT OR PARENT IF MINOR \_\_\_\_\_ DATE \_\_\_\_\_

**DOCTOR'S COMMENTS:** \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## PATIENT MEDICAL HISTORY