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PATIENT MEDICAL HISTORY & INFORMATION FORM

Name ______________________ Today's Date ______________________

Date of Birth ______________________ Soc. Sec. No. ______________________

Address ______________________ City ______________________

State __________ Zip Code __________ Home Phone (____) ______________________

Cell Phone (____) ______________________ Employer ______________________

Work Phone (____) ______________________ Spouse's Name ______________________

Spouse's Date of Birth ______________________ Spouse's Soc. Sec. No. ______________________

Spouse's Employer ______________________ Spouse's Work Phone (____) ______________________

Physician Name ______________________ Physician Phone (____) ______________________

Pharmacy ______________________ Pharmacy Phone (____) ______________________

Female only:

Are you taking birth control pills? **Y N**

Are you pregnant? **Y N** No. of wks __________

Are you nursing? **Y N**

List the medications you are currently taking:

____

____

____

Indicate which of the following you have had or have at present. Circle Y (Yes) *or* N (No) for each item.

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Allergies/Hives
Y N Anemia
Y N Arthritis/Rheumatism
Y N Artificial Heart Valve
Y N Artificial Joints
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Cosmetic Surgery
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Emphysema
Y N Epilepsy/Seizures
Y N Fainting Spells
Y N Fever Blisters
Y N Frequent Headaches

Y N Glaucoma
Y N HIV+ AIDS
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis A, B, or C (circle one)
Y N High Blood Pressure
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pace Maker
Y N Pneumocystitis
Y N Psychiatric Problems
Y N Radiation Therapy
Y N Rheumatic Fever
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Smoker/Tobacco User

Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis
Y N Tumors
Y N Ulcers
Y N Venereal Disease
Y N Yellow Jaundice

Allergies

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry
Y N Latex
Y N Metals
Y N Penicillin
Y N Tetracycline

Other______________________

____

____

____

Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe: ______________________

____

Patient Signature: ______________________ Date: ______________________