Patient Medical History

Name ______________________________ Today's Date____

Physician ___________________________ Phone ____

Please check all that apply:

__Do you smoke or chew tobacco? (**Circle one**)

__Have you been hospitalized in the past 2 years?

__ are you currently under medical treatment?

If so, why? _____________________________

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Are you allergic to:

__ Aspirin

__ Codeine or other narcotics

__ Latex

__ Penicillin

__ Sulfa Drugs

__ Sedatives

__Other______________________

Please list any medications you are currently taking: ______________________________________

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Do you have or have had any of the following?

GENERAL
__ Tire easily, weakness
__ Marked weight change
__ Sleep disorders_____________________________
__ Persistent fever
__ Migraines or frequent headaches

SKIN
__ Rash, hives
__ Change in skin color

EYES
__ Visual change
__ Glaucoma

EARS
__ Loss of hearing
__ Ringing in ears

THROAT
__ Soreness/hoarseness
__ Lumps/growths

NERVOUS SYSTEM
__ Stroke
__ Headaches
__ Convulsions/ Epilepsy
__ Numbness/ tingling
__ Dizziness/ fainting
__ Psychiatric Treatment
__ Depression

RESPIRATORY
__ Tuberculosis
__ Emphysema
__ Asthma/ hay fever
__ Persistent cough
__ Difficulty breathing

ENDOCRINE
__ Diabetes (TYPE) _______
__ Family history of diabetes
__ Thyroid condition
__ Other

HEART/BLOOD VESSELS
__ Rheumatic Fever
__ Heart murmur
__ Chest pain/discomfort
__ Heart attack/ trouble
__ Shortness of breath
__ Swelling of ankles
__ High blood pressure
__ Congenital heart disease
__ Mitral valve prolapse
__ Artificial heart valve
__ Pacemaker
__ Heart surgery
__ Stroke
__ Angina
__ Other

BONE/MUSCLES
__ Osteoporosis/ Bone density
(Bisphosphates Past or Present?)_______________
__ Arthritis/rheumatism
__ Artificial joints/ limbs

DIGESTIVE SYSTEM
__ Hepatitis
__ Jaundice
__ Ulcers
__ Change in appetite

URINARY
__ Kidney disease
__ Increase in frequency of urination
__ Burning with urination
__ Venereal disease

BLOOD
__ Bruise easily
__ Anemia
__ Blood Transfusion (DATE) ________
__ Blood disorders

OTHER
__ Radiation Treatment
__ Chemotherapy
__ Tumors or growth
__ Cancer
__ HIV/ AIDS
__ Sinus trouble
__ Herpes/ Cold sores
__ Alcoholism

Please list any medical condition NOT listed above:
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