

MEDICAL INFORMATION

NAME _____ DATE ____/____/20____

ALLERGIES: PENICILLIN: **YES NO** SULFA: **YES NO** LATEX: **YES NO** PAIN MEDS: **YES NO** TAPE: **YES NO**
SHELLFISH: **YES NO** IODINE: **YES NO** ASPIRIN: **YES NO** NOVOCAINE: **YES NO** ANESTHESIA: **YES NO**
OTHERS _____ FOODS _____

MEDICATIONS: ARE YOU ON A BLOOD THINNER? YES NO LIST ALL CURRENT PRESCRIPTIONS, NON-PRESCRIPTIONS & HERBAL SUPPLEMENTS

NAME	DOSE	HOW OFTEN	NAME	DOSE	HOW OFTEN
1. _____			4. _____		
2. _____			5. _____		
3. _____			6. _____		

MEDICAL CONDITIONS: DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? CIRCLE **YES OR NO**

DIABETES TYPE 1 OR 2	YES NO	HIGH BLOOD PRESSURE	YES NO	CONGESTIVE HEART FAILURE	YES NO
HIGH CHOLESTEROL	YES NO	IRREGULAR HEART BEAT	YES NO	DO YOU HAVE A PACE MAKER	YES NO
HEART MURMUR	YES NO	HEART ATTACK	YES NO	STENTS OR VALVE REPLACEMENT	YES NO
BLOOD CLOTS	YES NO	STROKE	YES NO	SEIZURES	YES NO
VARICOSE VEINS	YES NO	ANEMIA	YES NO	HEARTBURN/GERD/ULCER	YES NO
KIDNEY DISEASE	YES NO	KIDNEY STONES	YES NO	LIVER DISEASE:	YES NO
HEPATITIS A, B, C	YES NO	THYROID DISEASE	YES NO	SEASONAL ALLERGIES:	YES NO
SLEEP APNEA	YES NO	RHEUMATOID ARTHRITIS	YES NO	FIBROMYALGIA	YES NO
BACK PAIN	YES NO	ASTHMA	YES NO	COPD	YES NO
PREGNANT	YES NO	ON BIRTH CONTROL	YES NO	MEMORY PROBLEM:	YES NO
ANXIETY	YES NO	DEPRESSION	YES NO	SUICIDAL	YES NO
NEUROPATHY	YES NO	GOUT	YES NO	ON PAIN MEDS FOR CHRONIC PAIN	YES NO
POSITIVE HIV	YES NO	HERPES:	YES NO	CANCER:	YES NO
OSTEOPOROSIS	YES NO	GLAUCOMA	YES NO	OTHER:	YES NO

SURGERIES: LIST TYPE OF SURGERY _____ DATE _____

HOSPITALIZATIONS: (OTHER THAN FOR SURGERY) _____ DATE _____

FAMILY HISTORY -PLACE A CHECK MARK NEXT TO ANY FAMILY MEDICAL CONDITION

MOTHER : ALIVE OR DECEASED: __HEART __HIGH BLOOD PRESSURE __DIABETES __CANCER OTHER _____
FATHER : ALIVE OR DECEASED: __HEART __HIGH BLOOD PRESSURE __DIABETES __CANCER OTHER _____
SISTERS : ALIVE OR DECEASED: __HEART __HIGH BLOOD PRESSURE __DIABETES __CANCER OTHER _____
BROTHERS: ALIVE OR DECEASED: __HEART __HIGH BLOOD PRESSURE __DIABETES __CANCER OTHER _____

SOCIAL HISTORY

MARITAL STATUS: __ SINGLE __ MARRIED. __ PARTNERED __ SEPARATED. __ DIVORCED __ WIDOWED
ALCOHOL: __ NEVER __ NO LONGER USE __ HISTORY OF ALCOHOL ABUSE __ CURRENT __ DRINKS/DAY/WEEK
TOBACCO: __ NEVER __ QUIT - HOW LONG AGO? ____ __ SMOKE NOW __ PACKS/DAY FOR ____ YEARS
RECREATIONAL DRUGS: __ NEVER __ QUIT - HOW LONG AGO? ____ TYPE _____ CURRENT USE - TYPE _____
DO OTHERS DEPEND UPON YOU FOR THEIR CARE? __ CHILDREN-AGE(S) __ ELDERLY OR DISABLED __ PET(S)
EXERCISE: __ YES __ NO HOURS OF SLEEP PER NIGHT _____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS, MEDICATIONS OR INSURANCE CHANGES.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE