

MEDICAL HISTORY PERSONAL AND CONFIDENTIAL -Update needed every 5 yrs or event based

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Patient Name: _____

Date of Birth: ____ / ____ / ____

1. Primary Care Physician's (PCP) Name: _____
PCP office address: _____
a. Date of last physical: _____
b. Any conditions you are currently being treated for: _____

2. Have you been hospitalized in the last five (5) years: Yes No
a. When? _____ Reason? _____

3. Are you taking any medications? (Prescription, OTC, herbal, illicit, vitamins, other)..... Yes No
a. If yes, please list: _____

4. Have you had an allergic reaction to any medication, metal, latex or jewelry? Yes No
a. If yes, which ones? _____

5. Have you ever used diet drugs (e.g. Redux, Phenfen) Yes No a.
If yes, have you had an ultrasound heart exam? Yes No

6. Have you had trouble with prolonged bleeding after surgery? Yes No

7. Have you ever been diagnosed with cancer or a tumor? Yes No
a. If yes, your diagnosis: _____
b. Did you receive chemotherapy? Yes / No Radiation therapy? Yes / No
c. Date of last treatment: Month __ Year__

8. Have you ever taken medications for osteoporosis? Yes No

9. Please check if you have ever used: Tobacco? E-cigarettes? Marijuana? Smokeless Tobacco?

10. Please check, if yes, how much did/do you use? ____ cigarettes packs cans times blunts per day for ____ Years
a. If you are an ex-user, what year did you quit? _____

11. Do you have any history with the following conditions? **Please check or circle EACH response, as appropriate:**

Heart Attack Yes No	GERD/Reflux/Heartburn Yes No	Substance Abuse Yes No
Heart Murmur Yes No	Snoring/Sleep Apnea..... Yes No	Hepatitis Yes No
Heart Valve Problem..... Yes No	Daytime Sleepiness Yes No	AIDS/HIV Yes No
Rheumatic Fever Yes No	CPAP Use Yes No	HPV Yes No
Heart Disease Yes No	Asthma Yes No	Tuberculosis Yes No
Heart Surgery Yes No	Arthritis Yes No	Blood Transfusion..... Yes No
High Blood Pressure Yes No	Allergies/Hives Yes No	Anemia Yes No
Pacemaker Yes No	Emphysema Yes No	Taking Blood thinners ... Yes No
Angina Pectoris Yes No	Dry Mouth Yes No	Bruise Easily Yes No
Stroke Yes No	Gum/Mouth Surgery Yes No	Bleeding Problems Yes No
Diabetes Yes No	Epilepsy/Seizures Yes No	Psychiatric Care Yes No
Ulcers Yes No	Fainting/Dizziness Yes No	Anxiety/Depression Yes No
Kidney Trouble Yes No	Cold Sores Yes No	Autoimmune Disorder.... Yes No
Thyroid Problem..... Yes No	Artificial Joints Yes No	

Details, if needed: _____

Continued on back

12. Do you have any history of disease, condition or problem not listed above? Yes No
If yes, please list here: _____

13. **WOMEN:** Are you pregnant? ... Yes /No Nursing? ... Yes / No Taking Birth Control Pills? ... Yes / No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change(s) in my health, I will inform the doctor at the next appointment without fail.

X _____ Date: _____ Staff: _____
(Signature of patient, parent, or guardian)

EMERGENCY CONTACT (Name and phone number): _____