PATIENT MEDICAL HISTORY

Name_____ Date_____

If you are completing this form for another person, what is your relationship to that person?_____

In the following questions, circle **Y**es or **N**o, whichever applies:

1) Are you in good health? Y N 2) Date of last physical examination:_____

3) Has there been any change in your general health within the past year? Y N What?_____

4) Are you currently under the care of a physician? Y N For what condition?_____

Physician's name_____Address_____Phone No._____

5) Have you had any serious illness or operation within the past 5 years? Y N What?_____

6) Please list current medications, drugs or pills and dosages:_____

_____

7) Have you ever taken prescription weight-loss medication (e.g. *Phen-fen*)? Y N

8) Have you ever taken any oral or intravenous drugs for osteoporosis or bone tumors (e.g. *Fosamax*)? Y N

9) Do you or have you had any of the following diseases or problems? (circle if Yes)

cardiovascular disease (heart trouble, heart attack) high blood pressure cardiac pacemaker angina heart murmur
damaged or artificial heart valves rheumatic fever shortness of breath asthma tuberculosis persistent cough
arthritis seizures paralysis fainting spells joint replacement jaundice hepatitis cirrhosis
ulcers chronic diarrhea diabetes thyroid disorder hormonal disorder stroke anemia
bleeding disorder blood transfusion cancer treatment immunosuppressive disorder kidney disease glaucoma

Women: Are you: currently pregnant nursing taking oral contraceptives hormonal therapy

10) Are you allergic or have you reacted adversely to: (circle if Yes)

local anesthetics penicillin sulfa drugs sedatives aspirin codeine latex metals other_____

11) Do you have any health condition not listed above that you think we should know about? If so, explain_____

_____

12) Do you smoke or use tobacco? Y N If so, how much? _____

13) Are you using any recreational drugs? Y N If so, what? _____

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Signature_____Date_____

Reviewed By_____ Date_____ BP_____/_____ Pulse_____Temp_____

Doctor's Notes:_____

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