

MEDICAL HISTORY

PLEASE PRINT and USE BLACK or BLUE INK

Patient Name: _____ Date of Birth: _____
Last First Middle

Address: _____
Street City State Zip Area Code + Phone

Family Physician: _____
Name City Area Code + Phone Date of Last PHYSICAL

Please **CIRCLE** the appropriate answers.

Do you or have you ever had any of the following medical conditions?		
Heart Murmur	Yes	No
Rheumatic/Scarlet Fever	Yes	No
Heart Surgery	Yes	No
Artificial Heart Valves	Yes	No
Congenital Heart Defect	Yes	No
Mitral Valve Prolapse	Yes	No
Anemia	Yes	No
Bleeding Disorders	Yes	No
Blood Transfusions	Yes	No
Low/High Blood Pressure	Yes	No
HIV+ or AIDS	Yes	No
Cancer/Tumors/Chemotherapy	Yes	No
Leukemia	Yes	No
Diabetes	Yes	No
Fainting/Epilepsy/Seizures	Yes	No
Fever Blisters	Yes	No
Hepatitis (any type)	Yes	No
Kidney/Liver Problems	Yes	No
Osteoporosis/any bone disorders	Yes	No
Asthma/Breathing Difficulty	Yes	No
Tuberculosis	Yes	No
Venereal Disease	Yes	No
Liver/Kidney/any organ problems	Yes	No
Please list any other medical condition(s) that you have or had: _____ _____		

Are you in good health?	Yes	No
Are you under a physician's care for any reason?	Yes	No
If yes, please explain: _____ _____		
Are you currently taking any pills, medications, herbal, homeopathic or natural remedies?	Yes	No
If yes, please list type and dosage: _____ _____		
Do you smoke, or use any tobacco products?	Yes	No
If yes, what and how often: _____		
Do you have any learning disabilities?	Yes	No
If yes, please explain: _____ _____		

FOR PATIENTS UNDER 18 YEARS OF AGE			
Current height: _____		Current weight: _____	
Updated height: _____		Updated weight: _____	

FEMALES ONLY		
Are you or do you think you're pregnant?	Yes	No
If yes, how far along are you? _____		
Are you taking any type of birth control?	Yes	No
If yes, what type? _____		
If you're currently 16 or younger: What age was onset of menses? _____		

Are you allergic or have any reaction to any of the following?					
Aspirin	Yes	No	Jewelry/Metals	Yes	No
Codeine	Yes	No	Erythromycin	Yes	No
Latex	Yes	No	Penicillin	Yes	No
Food Dyes	Yes	No	Sulfa Drugs	Yes	No
Ibuprofen	Yes	No	Tetracycline	Yes	No
Artificial Flavors	Yes	No	Intense Light	Yes	No
Please list any other drugs/materials that you are allergic to: _____ _____					

MY SIGNATURE BELOW INDICATES THAT I HAVE COMPLETED THIS FORM TO THE BEST OF MY KNOWLEDGE.

Signature: _____
(Parent, Legal Guardian, or Patient only)

Date: _____ D-2: _____

DI1: _____ DI2: _____