Patient Medical History

Patient Name: ______________________________ DOB __________

Complete Address ______________________________ Zip: __________

Primary Physician ______________ Office Phone __________ Date of last exam __________

Have you been hospitalized for serious illness or surgical operations? Yes No If yes please list: __________

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Are you under medical treatment now? Yes No

Are you taking any medication including non-prescription? Yes No If yes, please list __________

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Do you smoke/use tobacco? Yes No Do you use alcohol? Yes No Cocaine? Yes No Other drugs? Yes No

Are you allergic to or have had a reaction to any of the following? (Circle all that apply)

Penicillin	Azithromycin	Hydrocodone	Aspirin	Sulfa Drugs
Amoxicillin	Erythromycin	Oxycodone	Latex	Codeine
Clindamycin	Cipro	Demerol	Iodine	Local Anesthetic
Keflex/Cephalexin	Augmentin	Ibuprofen	Sedatives	

Other: (please specify) ______________________________

Women Only

Are you pregnant or think you may be pregnant? Yes No Taking birth control pills? Yes No Nursing? Yes No

Do you have any of the following: (Circle all that apply)

Heart Disease or Attack	Pacemaker	Hepatitis	Drug Addiction
Heart Failure	Liver Disease	Diabetes	Cortisone Medication
Angina Pectoris	Kidney Trouble	Ulcers	Allergies or Hives
Congenital Heart Disease	Nervousness	Aids	Venereal Disease
Hardening of the Arteries	HIV Positive	Stroke	Blood Transfusion
Heart Murmur	Sinus Trouble	Asthma	Cole sores/Herpes
High Blood Pressure	Emphysema	Jaundice	Fainting or Dizzy Spells
Mitral Valve Prolapse	Cosmetic Surgery	Anemia	Chemotherapy
Artificial Heart Valve	Sickle Cell Disease	Arthritis	Radiation Therapy
Heart Surgery	Chronic Cough	Glaucoma	Pain in Jaw Joints
Thyroid Problems	Bruise Easily	Rheumatism	Psychiatric Treatment
Epilepsy or Seizures	Rheumatic Fever	Tuberculosis	Artificial Joints (Hips, Knee, etc.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this office of any changes in my medical status.

Signature ______________________________ Date __________

(Parent or Guardian if patient is a minor)