Medical History Form

Name: _____ _____ _____ Title: _____
Last First MI

Address: _____
Street Address City State Zip Code

Physician Name: _____

Physician Phone: ( ) _____

Date of your last physical Exam: _____

Your Current Health is: _____ Good _____ Fair _____ Poor

Are you now or have you recently been under the care of a physician? _____ Yes _____ No

If Yes, reason: _____

Have you ever had any serious illness or operation: _____ Yes _____No

Do you have or have you had any of the following medical conditions:

Yes	No		Yes	No		Yes	No	
___	___	Arthritis	___	___	High / Low Blood Pressure	___	___	Prolonged Bleeding
___	___	Rheumatic Fever	___	___	Hepatitis or Jaundice	___	___	Fainting Spells or Seizures
___	___	Heart Attack	___	___	Liver Disease	___	___	Epilepsy or Convulsions
___	___	Heart Murmur	___	___	Cancer or Tumor	___	___	Thyroid Disease
___	___	Mitral Valve Prolapse	___	___	Tuberculosis	___	___	Glaucoma
___	___	Artificial Heart Valves	___	___	Diabetes	___	___	Radiation Treatment
___	___	Chest Pain / Angina	___	___	Kidney / Bladder Trouble	___	___	Mental Disorders
___	___	Stroke	___	___	Anemia	___	___	HIV or AIDS
___	___	Shortness of Breath	___	___	Lung / Respiratory Disease	___	___	Prosthetic Joint Replacement
___	___	Asthma or Hay Fever	___	___	Venereal Disease	___	___	Blood Transfusion
___	___	Sinus Trouble	___	___	Blood Disease			

Are you currently taking any of the following Medications:

Yes	No		Yes	No	
___	___	Antibiotics or Sulfa Drugs	___	___	Insulin, Orinase, or Similar Drug
___	___	Anticoagulants (blood thinners)	___	___	Digitalis or other Heart Drug
___	___	Medicine for High Blood Pressure	___	___	Nitroglycerin
___	___	Cortisone (steroids)	___	___	Chemotherapy
___	___	Tranquilizers	___	___	Boniva, Actonel or similar Osteoporosis Preventative Drug
___	___	Antihistamines			
___	___	Aspirin on a Regular / Ongoing Basis	*Please list other Medications: _____		

Women:

Yes	No	
___	___	Are you currently pregnant
___	___	Are you taking birth control pills

Are you allergic to or had a reaction to:

Yes	No		Yes	No	
___	___	Local Anesthetic (Novicaine, etc.)	___	___	Sulfa Drugs or medicines containing Sulfur
___	___	Epinephrine found in some Local Anesthetics	___	___	Iodine
___	___	Penicillin or Other Antibiotics (*please specify)	___	___	Codeine or other Narcotics
___	___	Latex	___	___	Metals (rings, earrings, etc.)
___	___	Aspirin	___	___	Other. Please Explain: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medicines change, it is my responsibility to inform this office.

Signature Date