

PATIENT MEDICAL HISTORY

Patient's Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip _____

Home: _____ - _____ - _____ Work: _____ - _____ - _____ Cell: _____ - _____ - _____

Email: _____ Marital Status: _____

Date of Birth: ____/____/____ Gender: _____ Social Security Number: _____ - _____ - _____

INSURANCE INFORMATION:

Insurance Name: _____ Telephone: _____ - _____ - _____

Address: _____

Policy Owned By: Self OR Spouse Employer: _____

Employer Address: _____

Policy Holder Name: _____ Date of Birth: ____/____/____

Social Security Number: _____ - _____ - _____ Policy ID#: _____ Group# _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Telephone: _____ - _____ - _____ Relationship _____

MEDICAL HISTORY:

Female patients, please answer the following:

	YES	NO	
Are you taking Birth Control Pills?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, # of weeks: _____
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>	

<u>Allergies:</u>	YES	NO
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Dental Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>
Jewelry	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Metals	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>

Other Allergies: _____

Conditions:

	YES	NO		YES	NO
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hip Replacement Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Bones	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ Aids	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Knee Replacement Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer-Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Pneumocystitis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>

Please list any medications you may be taking:

Is there any disease, condition or problem that you think this office should be aware of that is not covered above? If yes, please describe below:

Any Additional Notes:

Patient Signature: _____ **Date:** _____

Print Name: _____