

Medical History Form

Date _____

Name _____ Home Phone (____) _____

Address _____ Business Phone (____) _____

City _____ State _____ Zip Code _____

Occupation _____ Social Security No. _____

Date of Birth (month/day/year) ____/____/____ Sex M F Height _____ Weight _____

____ Single ____ Separated ____ Divorced ____ Married - Name of Spouse _____

Name of Closest Relative Not in Household _____ Phone (____) _____

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

How did you hear about our office? _____

The name and address of my physician(s) is _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Yes No Are you in good health?
2. My last physical examination was on _____
3. Yes No Have you had any serious illness, operation, or been hospitalized in the past 5 years?
If so, what for? _____
4. Yes No Have you ever required a blood transfusion?
5. Yes No Are you now under the care of a physician?
6. Yes No Are you taking any medicine(s) including non-prescription medicine?
If so, what medicine are you taking? _____
- 7.. Yes No Has there been any change in your general health within the past year?
If so, what is the condition being treated? _____

Do you have or have you had any of the following diseases or problems?

8. Are you allergic or have you had a reaction to:

Yes	No	.....	Local anesthetics?
Yes	No	.....	Latex ?
Yes	No	.....	Penicillin or other antibiotics? Please list those you are allergic to _____
Yes	No	.....	Sulfa drugs?
Yes	No	.....	Barbiturates, sedatives, or sleeping pills?
Yes	No	.....	Aspirin?
Yes	No	.....	Iodine?
Yes	No	.....	Codeine or other narcotics?
Yes	No	.....	Other _____
9. Yes No Allergy or hay fever?
10. Yes No Sinus trouble?
11. Yes No Asthma, respiratory problems, emphysema, bronchitis, etc.?
12. Yes No Persistent cough or cough that produces blood?
13. Yes No Do you use tobacco products? If so, what kind and frequency: _____
14. Yes No Fainting spells or seizures?
15. Yes No Low blood pressure?
16. Yes No Persistent diarrhea or recent weight loss?
17. Yes No Stomach ulcer or hyper acidity
18. Yes No Have you had abnormal bleeding?
19. Yes No Do you have any blood disorder, such as anemia?
20. Yes No Diabetes?
21. Yes No Hepatitis, jaundice, or liver disease?
22. Yes No Problems of the immune system?
23. Yes No AIDS or HIV infection?
24. Yes No Sexually transmitted disease?

