Medical History Form

Patient's Last Name ______________________ Middle Initial _____ First Name ______________

Are you currently under the care of a physician? ❑ No ❑ Yes

For what reason: ____

When was your last physical exam? ____

Physician's Name ____

Address ________________________ Phone ________________ Last time seen ______

Have you ever been hospitalized? ❑ No ❑ Yes

If yes, please explain ____

Are you taking any prescription medication? ❑ No ❑ Yes

If yes, please explain ____

Are you taking any over the counter medication? ❑ No ❑ Yes

If yes, please explain ____

Do you have any allergies? ❑ No ❑ Yes

If yes, please explain ____

Are you allergic to any medications or substances? ❑ No ❑ Yes

If yes, please explain ____

Do you have any problems with antibiotics or anesthetics? ❑ No ❑ Yes

If yes, please explain ____

Do you take appetite suppressants? ❑ No ❑ Yes Name of product: ________________

Have you ever had any of the following diseases or medical conditions?

No	Yes	Condition	No	Yes	Condition
❑ No	❑ Yes	Heart Attack/Stroke	❑ No	❑ Yes	Epilepsy
❑ No	❑ Yes	Cancer/Chemotherapy	❑ No	❑ Yes	Seizures
❑ No	❑ Yes	Heart Murmur	❑ No	❑ Yes	Fainting
❑ No	❑ Yes	Rheumatic Fever	❑ No	❑ Yes	Diabetes
❑ No	❑ Yes	HIV/AIDS	❑ No	❑ Yes	Tuberculosis
❑ No	❑ Yes	Hepatitis A	❑ No	❑ Yes	Hemophilia
❑ No	❑ Yes	Hepatitis B	❑ No	❑ Yes	Blood Transfusion
❑ No	❑ Yes	Hepatitis C	❑ No	❑ Yes	High Blood Pressure
❑ No	❑ Yes	Hepatitis D	❑ No	❑ Yes	Low Blood Pressure
❑ No	❑ Yes	Anemia	❑ No	❑ Yes	Radiation Treatment
❑ No	❑ Yes	Mitral Valve Prolapse	❑ No	❑ Yes	Kidney Problems
❑ No	❑ Yes	Artificial Bones/Joints	❑ No	❑ Yes	Artificial Valves
❑ No	❑ Yes	Sinus Problems	❑ No	❑ Yes	Severe Headaches
❑ No	❑ Yes	Asthma	❑ No	❑ Yes	Frequent Headaches
❑ No	❑ Yes	Difficulty Breathing	❑ No	❑ Yes	Emphysema
❑ No	❑ Yes	Venereal Disease	❑ No	❑ Yes	Shingles
❑ No	❑ Yes	Herpes Type I	❑ No	❑ Yes	Herpes Type II
❑ No	❑ Yes	Heart Surgery	❑ No	❑ Yes	Pace Maker
❑ No	❑ Yes	Psychiatric Problems	❑ No	❑ Yes	Glaucoma
❑ No	❑ Yes	Do You Smoke?	❑ No	❑ Yes	Do You Consume Alcohol?

Are You Allergic To Any of The Following?

No	Yes	Substance	No	Yes	Substance
❑ No	❑ Yes	Penicillin	❑ No	❑ Yes	Codeine
❑ No	❑ Yes	Aspirin	❑ No	❑ Yes	Tetracycline
❑ No	❑ Yes	Erythromycin	❑ No	❑ Yes	Germicides/Pesticides
❑ No	❑ Yes	Latex/or Rubber Products	❑ No	❑ Yes	Other ________________

For Women Only:

No	Yes	Item	No	Yes	Item
❑ No	❑ Yes	Taking Birth Control Pills	❑ No	❑ Yes	Pregnant/No. of Months: ______
❑ No	❑ Yes	Nursing?	❑ No	❑ Yes	Hormone Therapy

Signature ____________________________________ Date ______________

Form #902

MEDICAL HISTORY FORM

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