

# Medical History

Name of patient \_\_\_\_\_ Age \_\_\_\_\_

Name of primary care physician \_\_\_\_\_

Date of most recent medical exam \_\_\_\_\_ Purpose of exam \_\_\_\_\_

Name and location of preferred pharmacy \_\_\_\_\_

How is your overall medical health? Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_ Excellent \_\_\_\_\_

Are you currently...

Y/N

- • Being treated for an illness
- • Experiencing a change in health
- • Often exhausted or fatigued
- • Having frequent headaches
- • Wearing a breathing device
- • Unhappy or depressed
- • Easily upset or irritated
- • Using chewing tobacco
- • A smoker
- • *Female* – taking birth control pills
- • *Male* – prostate disorder

Allergic reaction to...

Y/N

- • Aspirin/Ibuprofen/Tylenol
- • Penicillin
- • Erythromycin
- • Tetracycline
- • Codeine
- • Local anesthetic
- • Latex
- • Fluoride
- • Sulfa
- • Metals (gold/ stainless steel)
- • Other \_\_\_\_\_

Please list any recent medical conditions, treatments, or surgeries that you have had:

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Are you taking any of the following?

Y/N

- • Antibiotics/sulfa drugs
- • Antihistamines/allergy drugs
- • Cold remedies
- • Recreational drugs
- • Anti-Anxiety/Anti-Depressants
- • Cortisone/steroids
- • Insulin/Diabetes drugs

Y/N

- • Aspirin
- • Blood thinners
- • Blood pressure medication
- • Heart medications
- • Nitroglycerin
- • Thyroid medication
- • Osteoporosis medication

Please list all prescription medications, vitamins, and/or supplements that you are taking:

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(Please continue to other side)

Do you have any of the following medical conditions:

Y/N

General

- • Hospitalization for illness/injury
- • Tire easily, weakness
- • Marked weight change
- • Night sweats
- • Persistent fever
- • Rheumatic Fever

Heart/Blood Vessels

- • Swollen ankles
- • Chest pain/discomfort
- • High blood pressure
- • Congenital heart disease
- • Arrhythmia
- • Heart murmur
- • Mitral Valve Prolapse
- • Artificial heart valve
- • Heart attack
- • Heart surgery
- • Pacemaker

Respiratory System

- • Snoring
- • Sleep Disorder
- • Shortness of breath
- • Persistent cough
- • Asthma
- • Emphysema

Endocrine System

- • Diabetes
- • Family history of Diabetes
- • Thyroid condition

Bones/Muscles

- • Arthritis
- • Knee Replacement
- • Hip Replacement
- • Metal pins/plates

Y/N

Nervous System

- • Stroke
- • Chronic headaches
- • Epilepsy/seizures
- • Numbness/tingling
- • Dizziness/fainting
- • Psychiatric hospitalization

Ear, Nose, and Throat

- • Hearing loss
- • Ringing in ears
- • Frequent nosebleeds
- • Sinus problems/seasonal allergies
- • Hoarseness/sore throat
- • Tonsils / Adenoid Removed
- • Ear Tubes

Urinary System

- • Kidney disease
- • Kidney transplant
- • Frequent urination at night
- • Burning upon urination

Liver/Digestive System

- • Hepatitis A
- • Hepatitis B
- • Hepatitis C
- • Jaundice
- • Ulcers
- • Gastric Reflux

Other

- • Glaucoma
- • Anemia
- • Blood transfusion
- • Venereal disease
- • HPV
- • HIV
- • AIDS
- • Cancer
- • Radiation/chemotherapy

To the best of my knowledge, this health information is accurate.

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Patient Signature

Date

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Parent Signature if Under 18

Date