

Patient Medical History

Patient Name _____

Physician _____ Phone _____ Date of Last Exam _____

- 1. Are you under a doctor's care now?..... Yes / No
- 2. Have you been hospitalized for any surgeries or serious illness within the last 5 years? If yes, please explain: _____ Yes / No
- 3. Are you taking any medication(s) and/or non-prescription or herbal medicines?... Yes / No
If yes, please list medications/herbs you are taking _____
- 4. Have you ever taken Phen-Fen/Redux or appetite suppressants?..... Yes / No
- 5. Do you use tobacco?..... Yes / No
daily amount _____
- 6. Have you or Do you use street drugs?..... Yes / No
Specify _____
- 7. Do you consume alcohol?..... Yes / No
- 8. Do you wear contact lenses?..... Yes / No
- 9. Do you have or have you had any of the following? Yes / No
 - High/low Blood Pressure..... Yes / No
 - Blood transfusion..... Yes / No
 - Heart Trouble..... Yes / No
 - Attack/Stroke..... Yes / No
 - Heart Surgery..... Yes / No
 - Angina..... Yes / No
 - Pacemaker..... Yes / No
 - Heart Murmur..... Yes / No
 - Mitral Valve Prolapse..... Yes / No
 - Rheumatic Fever..... Yes / No
 - Require Premed?..... Yes / No
 - Diabetes..... Yes / No
 - Artificial Joint/Bone or Implant..... Yes / No
 - Asthma..... Yes / No
 - Emphysema..... Yes / No
 - Stomach Troubles/Ulcers..... Yes / No
 - Arthritis..... Yes / No
 - Are you taking Aspirin?..... Yes / No

- 10. Are you allergic to, or have had any reaction to the following?
 - Local Anesthetics (e.g. Novocain) Yes / No
 - Latex/or rubber products..... Yes / No
 - Codeine..... Yes / No
 - Penicillin or other Antibiotics..... Yes / No
 - Specify _____
 - Sulfa Drugs..... Yes / No
 - Barbiturates..... Yes / No
 - Iodine..... Yes / No
 - Any Metals (e.g. nickel, mercury, etc.. Yes / No
 - Specify _____
 - Kidney Diseases..... Yes / No
 - Hepatitis? Which type..... Yes / No
 - Liver Disease..... Yes / No
 - Epilepsy/Convulsions..... Yes / No
 - Cancer..... Yes / No
 - Radiation Therapy..... Yes / No
 - Tuberculosis..... Yes / No
 - AIDS or HIV Infection..... Yes / No
 - Sexually Transmitted Disease..... Yes / No
 - Thyroid Problems..... Yes / No
 - Fainting/ seizures..... Yes / No
 - Anemia..... Yes / No
 - Hay Fever/Allergies..... Yes / No
 - Frequently Tired..... Yes / No
 - Easily Winded..... Yes / No
 - Other..... Yes / No
 - Herpes Type I,II, Shingles..... Yes / No
 - Glaucoma..... Yes / No
- 11. Woman Only:
 - a) Are you pregnant or think you may be pregnant?..... Yes / No
 - b) Are you nursing?..... Yes / No
 - c) Are you taking contraceptives? Yes / No
If yes, which type _____
 - d) Hormone therapy..... Yes / No

Patient's signature _____ date _____

Parent/guardian if minor