

MEDICAL HISTORY FORM

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex: M / F

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

- 1. Are you in good health? Yes No
2. Has there been any change in your health in the past year? Yes No
3. My last physical exam was on / /
4. Are you now under the care of a physician? Yes No
If so, for what condition?
5. The name and address of my physician is:
6. Have you had any serious illness, operation or hospitalization within the past 5 years? Yes No
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? Yes No
8. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills Yes No
If so, please list
9. Do you have or have you had any of the following diseases or problems?
a. Damaged heart valves, artificial valves or heart murmur Yes No
b. Rheumatic Heart Disease Yes No
c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition Yes No
1. Chest pain upon exertion? Yes No
2. Shortness of breath after mild exercise? Yes No
3. Do your ankles swell? Yes No
d. Allergies Yes No
e. Sinus trouble Yes No
f. Asthma or hay fever Yes No
g. Fainting spells or seizures Yes No
h. Diabetes Yes No
i. Hepatitis, jaundice or liver disease Yes No
j. Frequent or recurring mouth sores Yes No
k. Thyroid problems Yes No
l. Respiratory problems, emphysema, bronchitis, etc. Yes No
m. Arthritis or painful, swollen joints including jaw joint (TMJ) Yes No
n. Stomach ulcer or hyperacidity Yes No
o. Kidney trouble Yes No
p. Tuberculosis Yes No
q. Persistent cough or cough that produces blood Yes No
r. Persistent swollen neck glands Yes No
s. Low blood pressure Yes No
t. Epilepsy or neurological disorder Yes No
u. Are you taking vitamins or homeopathic remedies Yes No
v. Cancer Yes No
w. Any disease, drug or transplant operation that has depressed your immune system Yes No

- |  |     |    |
|--|-----|----|
| 10. Have you had abnormal bleeding?.....   | Yes | No |
| a. Have you ever required a blood transfusion?.....  | Yes | No |
| 11. Do you have any blood disorder such as anemia?.....  | Yes | No |
| 12. Have you ever had treatment for a tumor or growth?.....  | Yes | No |
| 13. Are you allergic to or have you had a reaction to:   |     |    |
| a. Local anesthetics.....  | Yes | No |
| b. Penicillin or antibiotics.....  | Yes | No |
| c. Sulfa drugs.....  | Yes | No |
| d. Barbiturates or sleeping pills.....   | Yes | No |
| e. Aspirin.....  | Yes | No |
| f. Iodine.....   | Yes | No |
| g. Codeine or other narcotics.....   | Yes | No |
| h. Latex or rubber products.....   | Yes | No |
| i. Other.....  | Yes | No |
| If you answered yes to question "I" please list: _____   |     |    |
| 14. Do you have any other condition or disease you think the doctor should know about?.....  | Yes | No |
| If so, explain: _____  |     |    |
| 15. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel or Bonva), for osteoporosis, chemotherapy (Aredia or Zometa) for multiple myeloma, or other cancers? ..... | Yes | No |
| 16. Are you wearing contact lenses?.....   | Yes | No |
| 17. Are you wearing removable dental appliances?.....  | Yes | No |
| 18. Do you wish to talk with the doctor privately about anything?.....   | Yes | No |

**Women**

- |   |     |    |
|---|-----|----|
| 19. Are you pregnant or trying to become pregnant.....                | Yes | No |
| 20. Do you have problems associated with your menstrual period? ..... | Yes | No |
| 21. Are you nursing?.....   | Yes | No |
| 22. Are you taking birth control pills? .....                         | Yes | No |

**Reason for Appointment:** \_\_\_\_\_  
 \_\_\_\_\_

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_