

MEDICAL HISTORY FORM

PATIENT'S NAME: _____

TODAY'S DATE: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN?

NAME: _____ **ADDRESS:** _____ **CITY/STATE:** _____ **TELEPHONE NUMBER:** _____ **FAX NUMBER:** _____
 () _____ - _____ () _____ - _____

LIST ALL SERIOUS ILLNESSES FORMALLY DIAGNOSED BY A PHYSICIAN (INCLUDING THOSE YOU TAKE OR DO NOT TAKE MEDICATION FOR):

MEDICAL CONDITION:	DATE DIAGNOSED:	NAME AND TELEPHONE NUMBER OF TREATING PHYSICIAN:
_____	_____	_____ () _____ - _____
_____	_____	_____ () _____ - _____
_____	_____	_____ () _____ - _____
_____	_____	_____ () _____ - _____
_____	_____	_____ () _____ - _____

LIST ALL MEDICATIONS YOU ARE TAKING (INCLUDING VITAMINS/SUPPLEMENT, ETC.)

MEDICATION NAME:	FOR WHICH CONDITION?:	DOSE/INSTRUCTIONS:	PRESCRIBING M.D.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE CHECK "YES" OR "NO" TO THE FOLLOWING AND LIST ALL ALLERGIES YOU MAY HAVE OR SUSPECT YOU MAY HAVE:

MEDICATIONS? YES NO _____
 ANESTHETICS? YES NO _____
 INJECTIONS? YES NO _____
 LATEX RUBBER? YES NO _____
 TAPE? YES NO _____
 ENVIRONMENTAL? YES NO _____
 FOOD? YES NO _____
 OTHER: _____

LIST ALL SURGERIES:

TYPE OF SURGERY:	DATE PERFORMED:	NAME AND TELEPHONE NUMBER OF SURGEON:
_____	_____	_____ () _____ - _____
_____	_____	_____ () _____ - _____
_____	_____	_____ () _____ - _____
_____	_____	_____ () _____ - _____
_____	_____	_____ () _____ - _____

HAVE YOU EVER HAD ANY BLOOD TRANSFUSIONS? YES NO

HAVE YOU EVER HAD ANY BROKEN BONES? YES NO
 IF "YES," PLEASE LIST: _____

DO YOU SMOKE?: YES NO (IF YES, HOW OFTEN/HOW MUCH: _____)

LIST ALL FAMILY MEDICAL HISTORY/ CONDITIONS KNOWN (HEREDITARY):

MOTHER'S SIDE: _____ **FATHER'S SIDE:** _____

PLEASE LIST ANY ADDITIONAL MEDICAL INFORMATION WE SHOULD BE AWARE OF:

IF YOU REQUIRE ADDITIONAL ROOM TO WRITE, PLEASE CONTINUE ON THE REVERSE SIDE OF THIS FORM OR SUBMIT ADDITIONAL SHEETS AS NEEDED.