PATIENT MEDICAL HISTORY
For ages 13 and above

PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS _____

HOME PHONE _____WORK PHONE_____

CELL PHONE _____ E-MAIL _____

PHYSICIAN NAME _____ PHONE _____

PHARMACY _____ PHONE _____

IF FEMALE: Are you taking birth control pills? _____ Are you pregnant? _____
If pregnant, how many weeks? _____ Are you nursing? _____

Do you smoke or use tobacco? _____ Height _____ Weight _____

Please circle any of the following conditions that apply to you:

Abnormal bleeding
Alcohol abuse
Allergies
Anemia
Angina Pectoris
Arthritis
Artificial Bones
Artificial Heart Valve
Asthma
Blood Transfusion
Cancer-Chemotherapy
Colitis
Congenital Heart Defect
Cosmetic Surgery
Diabetes
Difficulty Breathing
Drug Abuse
Emphysema
Epilepsy
Frequent Headaches
Glaucoma
HIV+ AIDS
Hay Fever
Heart Attack
Heart Murmur
Heart Surgery
Hemophilia
Hepatitis A
Hepatitis B
High Blood Pressure
Kidney Problems
Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Pace Maker
Pneumocystitis
Psychiatric Problems
Radiation Therapy
Rheumatic Fever
Seizures
Shingles
Sickle Cell Disease
Sinus Problems
Stroke
Taken Fen-Phen
Thyroid Problems
Tuberculosis
Ulcers
Venereal Disease
Yellow Jaundice

ALLERGIES

Aspirin
Codeine
Dental Anesthetics
Erythromycin
Jewelry
Latex
Metals
Penicillin
Tetracycline
Other _____
_____

Is there any other disease, condition, or problem that you think this office should know about that is not covered above? _____

If yes, please describe

_____
_____
_____
_____

MEDICATIONS YOU ARE CURRENTLY TAKING

_____
_____
_____
_____
_____

SIGNATURE _____ **DATE** _____