



# Patient Medical History

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

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

Reason for Visit: \_\_\_\_\_

Who referred you to this office?: \_\_\_\_\_

## Medical Information

Are you in good health? ..... Yes No

Are you under the care of physician? ..... Yes No  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you been treated or evaluated by anyone else regarding today's visit? ..... Yes No  
Name: \_\_\_\_\_

Are you pregnant? ..... Yes No

Are you allergic to any medications, foods, latex, etc.? ..... Yes No  
Please List: \_\_\_\_\_

Are you presently taking any medications? ..... Yes No  
Please List: \_\_\_\_\_

Do you wear contacts? ..... Yes No

Do you smoke? ..... Yes No  
How much per day? \_\_\_\_\_ How many years? \_\_\_\_\_

## Have you had or currently have any of the following?

Rheumatic Fever	Y	N	Diabetes	Y	N
Damaged Heart Valves	Y	N	Low Blood Sugar	Y	N
Heart Murmur	Y	N	Kidney Problems/Dialysis	Y	N
High Blood Pressure	Y	N	Stomach Ulcers	Y	N
Chest Pain/Angina	Y	N	History of Cancer	Y	N
Heart Attack	Y	N	Radiation Treatment	Y	N
Irregular Heart Beat	Y	N	Chemotherapy	Y	N
Pacemaker	Y	N	Bruise Easily	Y	N
Asthma/Bronchitis	Y	N	Bleeding Tendency	Y	N
Sinus (disease)	Y	N	Sexually Transmitted Disease	Y	N
Tuberculosis	Y	N	Autoimmune Deficiency	Y	N
Difficulty Breathing	Y	N	Drug/Alcohol Addiction	Y	N
Shortness of Breath	Y	N	Glaucoma	Y	N
Swelling in Ankles/Legs	Y	N	Epilepsy/Convulsions/Fainting	Y	N
Head and Neck Surgery	Y	N	Stroke	Y	N
TMJ/Jaw Problems	Y	N	Liver Disease/Hepatitis	Y	N
Emphysema	Y	N	Thyroid Disorders	Y	N

I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. I have had the opportunity to discuss my health with my doctor and the information I have provided here is complete and accurate.

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

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_