Medical History Form

Today's Date:____________________________________

Patient Name:____________________________________

Date of Birth:____________________________________

When was your last physical exam?________________________

Physician's name:____________________________________

1. Are you currently under medical treatment?............. Yes No
Please describe:____________________________________

2. Have you ever had any serious illnesses/operations? Yes No
Please describe (include year):________________________

3. Are you currently taking any medications?............. Yes No
Describe these below including over-the-counter medicines, and those taken only "as needed".

Medication Name	Tablet Size	Frequency

4. Do you smoke?..Yes No 5. Do you use alcohol?....Yes No

6. Have you had any allergic reactions to the following:

Local Anesthetics (such as Novocaine)…………………. Yes No
Sedatives…………………………………………………. Yes No
Penicillin or other Antibiotics…………………………… Yes No
Iodine……………………………………………………... Yes No
Sulfa Drugs………………………………………………. Yes No
Aspirin…………………………………………………….. Yes No
Barbiturates (sleeping pills)……………………………. Yes No
Other………………………………………………………. Yes No
Please describe:____________________________________

7. Family History: List any diseases/illnesses that run in your family.

	Current Age	If Deceased, Age of Death	If Deceased, Cause of Death
Mother			
Grandmother (Maternal)			
Grandfather (Maternal)			
Father			
Grandmother (Paternal)			
Grandfather (Paternal)			
Sister(s)			
Brother(s)			

8. Women Only: Do you have regular periods?.................Yes No
Are you taking birth control pills?..Yes No
Are you (or could you be) pregnant?.................................. Yes No

9. Have you ever had: Yes No

Anemia (low blood count)……….. ☐ ☐
Anorexia (no appetite)…………….. ☐ ☐
Arthritis……………………………. ☐ ☐
Asthma…………………………….. ☐ ☐
Back problems……………………… ☐ ☐
Bleeding tendency………………… ☐ ☐
Blood disease……………………… ☐ ☐
Cancer……………………………… ☐ ☐
Chemical dependency ……………. ☐ ☐
Chemotherapy……………………… ☐ ☐
Chicken pox………………………… ☐ ☐
Chronic fatigue syndrome………….. ☐ ☐
Circulatory problems………………. ☐ ☐
Congenital heart lesions…………… ☐ ☐
Cough – persistent or bloody……… ☐ ☐
Diabetes……………………………. ☐ ☐
Emphysema………………………… ☐ ☐
Epilepsy……………………………. ☐ ☐
Glaucoma…………………………… ☐ ☐
Heart murmur………………………. ☐ ☐
Heart attack/disease……………….. ☐ ☐
Hepatitis-Type____......................... ☐ ☐
Hernia………………………………. ☐ ☐
Herpes………………………………. ☐ ☐
High blood pressure……………….. ☐ ☐
High cholesterol……………………. ☐ ☐
HIV/AIDS……………………………. ☐ ☐
Jaundice……………………………. ☐ ☐
Kidney disease…………………….. ☐ ☐
Latex sensitivity…………………… ☐ ☐
Liver disease………………………. ☐ ☐
Low blood pressure………………. ☐ ☐
Measles……………………………. ☐ ☐
Migraine headaches………………. ☐ ☐
Mitral valve prolapse……………… ☐ ☐
Mumps……………………………… ☐ ☐
Multiple sclerosis…………………. ☐ ☐
Pacemaker………………………… ☐ ☐
Pneumonia………………………… ☐ ☐
Polio………………………………… ☐ ☐
Prostate problem…………………. ☐ ☐
Psychiatric care…………………… ☐ ☐
Respiratory disease………………. ☐ ☐
Rheumatic fever………………….. ☐ ☐
Scarlet fever………………………. ☐ ☐
Shortness of breath………………. ☐ ☐
Sinus trouble………………………. ☐ ☐
Skin rash……………………………. ☐ ☐
Stroke………………………………. ☐ ☐
Thyroid problems…………………. ☐ ☐
Tonsillitis…………………………… ☐ ☐
Tuberculosis……………………….. ☐ ☐
Tumor………………………………. ☐ ☐
Ulcer………………………………… ☐ ☐
Venereal disease………………….. ☐ ☐
Other (specify)…………………….. ☐ ☐