Medical History *(All information will be kept confidential)*

Patient's Name: ______________________ Birthdate: ______________

Primary Care Physician: ______________ City: __________ Phone: ______________

List MEDICAL SPECIALISTS you have seen:

1. Physician's Name: ______________________ Specialty: ______________

2. Physician's Name: ______________________ Specialty: ______________

Describe your overall health:

☐ Excellent (Better than most people my age) ☐ Good (I am not aware of any medical problem)
☐ Fair (I have some health problems but they're under control) ☐ Guarded (I have some current health problems)
☐ Poor (I have some major health problems)

When was the last time you saw your physician? ___________(Year) What was the purpose? ______________
Have you ever been hospitalized or had a serious illness? ☐ No ☐ Yes, describe: ______________

HABITS

☐ N/A ☐ Cigarettes ☐ Vape ☐ Cigars ☐ Pipe If yes, please answer below

- ☐ Smoked but quit. When? __________ ☐ Currently Smoking. Amount? __________ Start Date:__________

WOMEN

Are you pregnant? ☐ No ☐ Yes, estimated due date______________ Are you nursing? ☐ No ☐ Yes
Are you taking oral contraceptives? ☐ No ☐ Yes Are you undergoing hormone replacement therapy? ☐ No ☐ Yes

MEDICATIONS

Are you under treatment for Osteoporosis and taking a class of medications called Bisphosphonates? ☐ No ☐ Yes

- Some common names include ☐ Actonel ☐ Boniva ☐ Fosamax ☐ Fosamax Plus D ☐ Other:______________

Are you taking any blood thinner? ☐ No ☐ Yes
Some common names include ☐ Plavix ☐ Ticlid ☐ Lovenox ☐ Coumadin/Warfarin ☐ Other:______________

ALLERGIES

Are you allergic to any of the following?
☐ Latex ☐ Penicillin ☐ Sulfa ☐ Other antibiotics ☐ Codeine ☐ Local anesthetic ☐ Aspirin ☐ NSAIDs like Motrin
☐ Metals ☐ Vicodin ☐ Percocet ☐ Other ______________
☐ Check here, if no known allergies

Name the specific medication and describe your reaction: ______________________

List any surgeries or major health events	
Year	**Event**

Medications INCLUDING over-the-counter medications and herbal supplements		
Name of Medicine	**Dosage**	**Purpose: Why are you taking it?**

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

HEART/VASCULAR
- ☐ Heart attack (MI)
- ☐ Congenital heart defect
- ☐ Rheumatic Fever
- ☐ Irregular heartbeat (missed beats)
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Angina / Chest pain
- ☐ Mitral Valve Prolapse
- ☐ Artificial heart valve(s)
- ☐ Pacemaker
- ☐ By-pass surgery
- ☐ Stent replacement
- ☐ Congestive heart failure
- ☐ Swelling of ankles
- ☐ Shortness of breath

BLOOD
- ☐ Anemia
- ☐ Sickle cell disease
- ☐ Hemophilia
- ☐ Bruise very easily
- ☐ Prolonged bleeding
- ☐ HIV / AIDS

RESPIRATORY
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Asthma
- ☐ Persistent cough
- ☐ Coughing up blood / sputum
- ☐ Difficulty breathing while lying down
- ☐ Winded going up a flight of stairs
- ☐ Lung cancer
- ☐ Other lung disease

BONE
- ☐ Arthritis / Rheumatism
- ☐ Osteoporosis
- ☐ Gout
- ☐ Artificial joints or limbs

URINARY
- ☐ Kidney disease
- ☐ Renal dialysis
- ☐ Frequent urination
- ☐ Burning with urination
- ☐ Blood or discharge in urine
- ☐ Venereal disease
- ☐ Genital herpes

NERVOUS SYSTEM
- ☐ Stroke (CVA) or TIA
- ☐ Severe headaches / Migraine
- ☐ Fainting or dizzy spells
- ☐ Convulsions or Epilepsy
- ☐ Numbness or tingling

ENDOCRINE
- ☐ Diabetes: Type I Type II
- ☐ Excessive thirst
- ☐ Thyroid disease
- ☐ Hypoglycemia

MENTAL HEALTH
- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Psychiatric treatment
- ☐ Bipolar (manic – depressive)
- ☐ Addictive disorders _______
- ☐ Other ___________________

HEAD/NECK/EYES
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Loss of hearing.
- ☐ Tonsillitis
- ☐ Sinus problems

DIGESTIVE SYSTEM
- ☐ Hepatitis, Type ___
- ☐ Gastric reflux
- ☐ Ulcers
- ☐ Frequent diarrhea
- ☐ Crohn's disease or colitis

CANCER
- ☐ Tumor ___________________
- ☐ Radiation treatment
- ☐ Chemotherapy
- ☐ Organ removal
  Organ: _________ Date: _______
- ☐ **ORGAN TRANSPLANT**
  Organ: _________ Date: _______

To the best of my knowledge, all the above information is correct.

Signature: ________________________________ **Date:** _______________

Doctor Notes: