PATIENT MEDICAL HISTORY

Patients Name: _____Today's Date: _____

Height: _____Weight: _____ Gender: _____ If Patient a Minor, Who is Accompanying the Patient Today? _____

Name of Physician: _____Phone: _____

Date of Last Visit: _____Reason for Last Visit: _____

For Women:

Date of last menstrual cycle: _____ Are you pregnant? ☐NO ☐YES, How far along? _____

Are you nursing? ☐YES ☐ On birth control? ☐YES ☐NO Is there any chance that you may be pregnant? ☐YES ☐NO

Have you ever had any of the following diseases or medical problems? (please check ☑)

Medical Condition	Y	**N**	**Medical Condition**	**Y**	N	**Medical Condition**	Y	**N**
AIDS			Drug Abuse			Knee Replacement		
Alcohol Abuse			Emphysema			Joint Replacement		
Anemia			Epilepsy			Liver Disease		
Arthritis			Fainting			Mitral Valve Prolapse		
Asthma			Heart Attack			Pacemaker		
Bleeding Problems			Heart Murmur			Radiation Treatment		
Blood Transfusion			Heart Surgery			Rheumatic Fever		
Breathing Problems			Heart Valve Replacement			Seizures		
Cancer/Chemotherapy			Hemophilia			Sinus Problems		
Colitis			Hepatitis			Steroid Therapy		
Congenital Heart Defect			High Blood Pressure			Subacute Bact Endocarditis		
Defibrillator			Hip Replacement			Thyroid Treatment		
Diabetes			HIV			Ulcers		
Dizzy Spells			Kidney Problems			Other? Please specify Below		

Other Medical Conditions:

_____

Have you ever taken bisphosphonates (used to treat osteoporosis & certain types of cancer). ☐YES ☐NO

Allergies (please check ☑)						Current Medications		
	Y	**N**		**Y**	**N**	Name of Prescription	Dose	Condition
Penicillin			Latex					
Antibiotics			Local Anesthetic					
Aspirin			Bleach					
Tylenol			Ibuprofen					
Codeine			Nitirle					
Narcotics			EDTA					
Sulfa/Sulfides			Valium/Tranquil					
Other Allergies? Please Specify:_____								
_____								

Surgical History:

Type: _____ Date: _____ Any Complications? _____

Type: _____ Date: _____ Any Complications? _____

Type: _____ Date: _____ Any Complications? _____

Statement of Accuracy: I certify that the information provided in this health history is accurate and complete to the best of my recollection. I acknowledge the importance of an honest health history for the purpose of receiving optimal medical care.

Record of Visit:

1st Visit: Patient Signature: _____Date: _____

Doctor Signature: _____ Date: _____

2nd Visit: Patient Signature: _____ Date: _____

Doctor Signature: _____Date: _____