

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

City State Zip:

Email:

Home Phone:

Work Phone:

Birth Date:

Social Security No.:

Marital Status:

Guarantor 1:

Home Phone:

Work Phone:

Guarantor 2:

Home Phone:

Work Phone:

Physician Name:

Physician Phone:

Pharmacy:

Pharmacy Phone:

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y N

Are you taking Birth Control Pills?

Are you pregnant?

If Yes, # of weeks

Are you nursing?

Please answer the following:

Y N

Do you smoke or use tobacco?

Height:

For Office Use Only

BP

Heart Rate:

Weight:

Y N **Conditions**

- 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
- Fainting Spells
- Fever Blisters
- Frequent Headaches

Y N **Conditions**

- Glaucoma
- Hay Fever
- Heart Attack
- Heart Surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- High Blood Pressure
- HIV+ AIDS
- 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

Y N **Conditions**

- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease
- Yellow Jaundice

Y N **Allergies**

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Jewelry
- Latex
- Metals
- Penicillin
- Tetracycline

Other

Medications:

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Y N

Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below...

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Notes:

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Signature: _____

Date: _____

(If Under 18, Parent or Guardian Signature Required)