Medical History

Name _____ DOB _____ Date_____

Preferred Phone #: _____ Address _____

DO YOU HAVE ANY OF THE FOLLOWING

	CIRCLE ONE	
HIGH BLOOD PRESSURE	YES	NO
LOW BLOOD PRESSURE	YES	NO
ASTHMA	YES	NO
RESPIRATORY DISEASE	YES	NO
HAY FEVER	YES	NO
ALLERGIES	YES	NO
SINUSITIS	YES	NO
DIABETES	YES	NO
RHEUMATIC FEVER	YES	NO
TUMORS	YES	NO
GROWTHS	YES	NO
GLAUCOMA	YES	NO
PROSTHETIC JOINT REPLACEMENT	YES IF YES DO YOU PRE-MED?	NO
RHEUMATISM	YES	NO
ARTHRITIS	YES	NO
ANY BLOOD DISEASE	YES	NO
ABNORMAL BLEEDING FROM CUTS	YES	NO
TUBERCULOSIS	YES	NO
EPILEPSY OR SEIZURES	YES	NO
HEART MURMUR	YES	NO
ABNORMAL HEART CONDITIONS	YES	NO
CARDIOVASCULAR DISORDER	YES	NO
STROKE	YES	NO
HERPES VIRUS	YES	NO
THYROID DISEASE	YES	NO
HEPATITIS OR JAUNDICE (YEAR: ___)	YES	NO
KIDNEY DISEASE	YES	NO
FREQUENT FAINTING SPELLS	YES	NO
STOMACH OR INTESTINAL DISEASE/DISORDER	YES	NO
ANY LIVER DISEASE	YES	NO
HIV	YES	NO
ALZHEIMERS / DEMENTIA	YES	NO
PARKINSON'S DISEASE	YES	NO
Cancer	YES	NO

Are you allergic to any drugs, medications, or foods?

Yes No

If yes, please list below

_____

Have you ever had radiation treatment?

Yes No

Are you currently taking any drugs or medications?

Yes No

****IF YOU HAVE A MEDICATION LIST WE CAN MAKE A COPY OF IT FOR YOU****

If so, please list the drug or medication	For what

List all hospitalizations during the past 5 years

YEAR	HOSPITAL/CITY	REASON	COMPLICATIONS

History of bone-density drugs? Yes No

Women: Are you pregnant? Yes No

If yes, what month _____

I certify that the answers given are true and complete to the best of my knowledge:

Signature: _____ Date: _____