

Please complete this form and bring it with you to your appointment.

NAME (please print) _____ DOB: _____

PATIENT'S PAST MEDICAL HISTORY

Please circle 'yes' or 'no' for the following medical problems as they apply to you, past or present, and explain

 HT: _____
 WT: _____

General		Cardiovascular	
Yes	No	Allergy _____	Yes No Pacemaker/Defibrillator _____
		Reaction: _____	Yes No Heart Problems _____
Yes	No	Allergy-LATEX _____	Yes No High Blood Pressure _____
Yes	No	Birth Defect _____	Yes No Stroke _____
Yes	No	Cancer _____	Gastro-intestinal
Yes	No	Diabetes _____	Yes No Bowel Disorder _____
Yes	No	Diphtheria _____	Yes No Gallbladder Problems _____
Yes	No	Emotional Difficulty _____	Yes No Hepatitis / Jaundice _____
Yes	No	Epilepsy / Seizures _____	Yes No Liver Problems _____
Yes	No	HIV / AIDS _____	Yes No Reflux Disease _____
Yes	No	Polio _____	Yes No Ulcer _____
Yes	No	Rheumatic Fever _____	Genito-urinary
Yes	No	Scarlet Fever _____	Yes No Kidney Problems _____
Yes	No	Thyroid Disease _____	Yes No Sexually Transmitted Disease _____
Blood		Orthopedic	
Yes	No	Anemia _____	Yes No Arthritis (Degenerative, Rheumatoid) _____
Yes	No	Bleeding Tendencies _____	Yes No Arthritis (Lupus, Scleroderma) _____
Yes	No	Blood Clot _____	Yes No Fracture (Broken Bone) _____
Yes	No	Blood Transfusions _____	Yes No Nerve Compression / Irritation _____
Respiratory		Miscellaneous	
Yes	No	Asthma _____	Yes No Hospitalized _____
Yes	No	Lung Disease _____	Yes No Other Medical Problems _____
Yes	No	Pneumonia _____	Yes No Surgery _____
Yes	No	Pulmonary Embolism (Blood Clot in Lung) _____	
Yes	No	Tuberculosis (TB) _____	

 Have you taken Cortisone or Steroid type drugs? Yes No
 What _____ Dosage _____ When _____

 Do you drink alcoholic beverages? Yes No
 If so, what type of alcohol? _____ Average amount per week? _____

 Do you or have you used tobacco products? Yes No
 If so, what type of tobacco? _____ How Long? _____
 Average amount per day? _____

 Do you or have you used street drugs? Yes No
 If so, what kind? _____ Average amount per week? _____

FAMILY HISTORY

If your parents, brothers or sisters have had or currently have any of the following, please circle the appropriate answer and explain.

Yes	No	Allergy _____	Yes	No	Tuberculosis (TB) _____
Yes	No	Cancer _____	Yes	No	Heart Problems _____
Yes	No	Diabetes _____	Yes	No	High Blood Pressure _____
Yes	No	Epilepsy / Seizures _____	Yes	No	Kidney Problems _____
Yes	No	Anemia _____	Yes	No	Arthritis _____
Yes	No	Bleeding Tendencies _____	Yes	No	Back or Neck Problems _____

Patient's Signature _____ Date _____