Medical Health History ==========

PATIENT NAME: _____ **DATE:** _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ **OFFICE PHONE** _____
DATE OF LAST EXAM _____ **MEDICAL ALERTS** _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or illness? If yes, please give details _____	☐	☐
3. Are you taking any medications including Non-prescription medicine?	☐	☐

If yes, what medications are you taking? _____ _____
_____ _____
_____ _____

	YES	NO
4. Do you use tobacco?	☐	☐
5. Do you use alcohol?	☐	☐
6. Do you use cocaine or other drugs?	☐	☐
7. Are you wearing contact lenses?	☐	☐

WOMEN ONLY

	YES	NO
A) Are you pregnant?	☐	☐
B) Are you nursing?	☐	☐
C) Are you taking birth control pills?	☐	☐

8. **Are you allergic to or have you had any reactions to the following?**

	YES	NO		YES	NO
Local anesthetics	☐	☐	Barbiturates	☐	☐
Penicillin or other antibiotics	☐	☐	Sedatives	☐	☐
Sulfa drugs	☐	☐	Iodine	☐	☐
Latex	☐	☐	Aspirin	☐	☐
Codeine or other narcotics	☐	☐	Other	☐	☐

9. **Do you have or have you had any of the following?**

	YES	NO		YES	NO		YES	NO
Heart Murmur	☐	☐	Stroke	☐	☐	Sickle Cell Anemia	☐	☐
Joint Replacement	☐	☐	Angina	☐	☐	Kidney Disease	☐	☐
Implant	☐	☐	Hay fever/allergies	☐	☐	Liver Disease	☐	☐
High Blood Pressure	☐	☐	Fainting/seizures	☐	☐	Hepatitis	☐	☐
Heart Disease	☐	☐	Tuberculosis	☐	☐	AIDS/HIV Infection	☐	☐
Chest Pains	☐	☐	Asthma	☐	☐	Sexually Trans. Disease	☐	☐
Heart Attack	☐	☐	Anemia	☐	☐	Respiratory Problems	☐	☐
Cardiac Pacemaker	☐	☐	Radiation therapy	☐	☐	Thyroid Problems	☐	☐
Rheumatic Fever	☐	☐	Epilepsy/ Leukemia	☐	☐	Stomach Ulcers	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Other:_____		
Diabetes	☐	☐	Cancer	☐	☐	_____		
Leukemia	☐	☐	Arthritis	☐	☐	_____		

SIGNATURE: _____ **DATE:** _____