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MEDICAL HISTORY

Patient Name:	Date:	
Date of birth:	Height: Weight:	
Reason for today's visit:		
Please check any of the following cond	itions that you now have (or have ever ha	d):
□Asthma	☐Abnormal Chest x-ray	☐ Blood clots in lung
☐ Hay Fever	☐ High blood pressure	□Seizures
☐Allergy Problems	☐Chest Pain	☐ Nervous Disorders
□Hives	☐ Heart Attack	□Shingles
☐Allergic reaction to	☐Heart Murmur	□Stroke
Local Anesthesia	☐ Irregular heartbeat	☐ Faint easily
☐Skin cancer	\Box Joint pains/arthritis	□Glaucoma
☐ Family history of skin	\square Thyroid problems	□ Cataracts
Cancer	\square Kidney disease	□Diabetes
☐ Positive skin test for TB	☐Cold sores	☐Liver disease
☐Stomach problems	□Pacemaker	\square Hepatitis
□Anemia	\square Mitral valve prolapse	☐ Artificial joints
☐ Artificial heart valve	☐ Exposure to AIDS	
Y□N□ I take aspirin	Y $□$ N $□$ I take a blood thinner	Y□N□ I take antibiotics before surgical procedures
I take the following medications/herba	ıl supplements:	
I am allergic to the following medication	ons:	
I have had the following surgeries:		
I drinkalcoholic beverages per v	veek	I smokecigarettes per day
I am/am not pregnant		I am/am not now nursing
		·
i nave the following medical condition	ns not mentioned above:	
My personal physician is:		
My pharmacy of choice is:		
Completed by:	□Nurse	

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