CONFIDENTIAL MEDICAL HISTORY

PATIENT NAME_____ SS#_____ BIRTH DATE_____

ADDRESS_____ PHONE_____

CITY_____ STATE_____ ZIP_____ MALE___ FEMALE___

EMERGENCY CONTACT_____ PHONE _____

Do You Have or Have Had…

__High or Low Blood Pressure (Circle)
__Asthma or Breathing Problems
__Arthritis
__Cold Sores or Herpes
__Diabetes
__Convulsions or Epilepsy
__Hepatitis, Type ___
__Heart Pacemaker
__Bleeding Problems
__Alcohol or Drug Dependency
__Thyroid Problems
__Tumor, Malignant or Benign
__Radiation Treatment
__Chemotherapy
__Tuberculosis
__Latex Allergy
__Stroke
__Kidney Problems
__Tobacco Usage
__Mitral Valve Prolapse
__Artificial Joint Placement
__Heart Murmur
__Rheumatic Fever
__Stents or Shunts
__Autoimmune Problems
__HIV, ARC, AIDS

List Drug Allergies_____

Are You Being Treated BY Physician For Any Condition?_____

What Medications or Drugs are using now?_____

_____

Are You Pregnant or Trying to Become Pregnant?_____

Are You in Good Health?_____ Approximate Date Of Last Physical?_____

Physicians Name and Address: _____

Is There Any other Information That Should Be Known About Your Health?_____

MEDICAL HISTORY UPDATE

DATE	CHANGES IN MEDICATION, HEALTHHISTORY ILLNESSES, SURGERIES	DR. / HYG.
_____	_____	_____
_____	_____	_____
_____	_____	_____
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Signature: _____ Date:_____