Patient Medical History

Name_____ Date of Birth_____ Age_____

Address_____ Marital Status_____

City_____ State_____ Zip Code_____

Tel. Number (Home)_____ (Cell/Business)_____

Occupation_____

How did you hear about our office?_____

Email Address_____ Best way to contact you_____

Do you have now, or have you ever had diseases or conditions of: *(If yes, please check box)*

Lungs

☐ Bronchitis ☐ Emphysema ☐ Asthma ☐ Chronic Cough ☐ Morning Cough

Vascular

☐ High Blood Pressure ☐ Chest Pain ☐ Heart Attack ☐ Heart Murmur
☐ Irregular Heartbeat ☐ Pacemaker ☐ Blood Clots/Phlebitis ☐ Mitral Valve Prolapse

Other Systemic

☐ Diabetes ☐ Thyroid ☐ Kidney ☐ Bladder ☐ Stomach
☐ Bowel ☐ Hepatitis A/B/C ☐ Glaucoma ☐ Arthritis/Joint

Current Medication	**Y**	**N**	If yes, please list:	What happens?:
Do you have any allergies to food or medicine?	☐	☐		.
Do you currently use any prophylactic antibiotics?	☐	☐	Which one?	.
Are you currently taking any medications?	☐	☐	Please list:	.
Are you taking any vitamins or herbal supplements?	☐	☐	Please list:	.
Are you taking any over the counter medications?	☐	☐	Pleast list:	.
Do you drink alcohol?	☐	☐	How much?	How often? .
Do you currently use IV drugs?	☐	☐	Please list:	.
Have you ever been exposed to HIV/AIDS?	☐	☐	.	
Have you ever had a blood transfusion?	☐	☐	.	
Do you have an allergy to latex?	☐	☐	.	

Skin	**Y**	**N**
Do cuts on your skin heal with normal scars?	☐	☐

List any other disease or condition we should be aware of:_____

List surgical procedures (including cosmetic procedures):_____

Please answer the following questions	**Y**	**N**		**Y**	**N**
Do you smoke?	☐	☐	*Women:* Are you pregnant?	☐	☐
Do you bleed easily?	☐	☐			
Do you have artificial joints, pins or screws?	☐	☐	Have you had a hysterectomy?	☐	☐
Do you require antibiotics prior to surgery?	☐	☐	Have you experienced menopause?	☐	☐

_____ _____
Patient's Signature Date

_____ _____
Physician / Physician's Assistant Signature Date