Confidential Medical History

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PLEASE ANSWER ALL QUESTIONS BY MARKING EACH LINE YES OR NO:

DO YOU HAVE AT THIS MOMENT OR IN THE PAST EVER HAD THE FOLLOWING MEDICAL PROBLEMS:

	Y	N		Y	N		Y	N
STROKE	()	()	**ANEMIA**	()	()	CONVULSIONS	()	()
RHEUMATIC FEVER	()	()	ARTHRITIS	()	()	FAINTING SPELLS	()	()
HEART MURMUR	()	()	STOMACH ULCERS	()	()	NERVOUS DISORDER	()	()
HEART ATTACK	()	()	THYROID DISEASE	()	()	PSYCHIATRIC/MENTAL		
ANGINA	()	()	KIDNEY DISEASE	()	()	DISORDER	()	()
HEART SURGERY	()	()	DIABETES	()	()	CLICKING OR POPPING OF		
PACEMAKER PLACED	()	()	LIVER DISEASE	()	()	JAW JOINT, PAIN NEAR EAR	()	()
CONGENITAL HEART DIS.	()	()	ASTHMA	()	()	NASAL OR SINUS PROBLEM	()	()
HIGH BLOOD PRESSURE	()	()	EMPHYSEMA	()	()	PANCREATITIS	()	()
CORONARY ARTERY DIS.	()	()	BLEEDING DISORDER	()	()	CHRONIC COUGH	()	()
TREATMENT FOR CANCER	()	()	GLAUCOMA	()	()	BRONCHITIS	()	()
IMPLANTS PLACED			BRUISE EASILY ESP. AFTER			PNEUMONIA	()	()
ANYWHERE IN YOUR BODY	()	()	DENTAL WORK	()	()	SEIZURES/EPILEPSY	()	()
TUBERCULOSIS	()	()	SHORTNESS OF BREATH	()	()	**ANXIETY/PANIC**	()	()
						ATTACKS		

ARE YOU USING OR TAKING **ANY OF THE FOLLOWING MEDICATIONS:**

	Y	N		Y	N		Y	N
ANTIBIOTICS OR SULFA	()	()	THYROID MEDICATION	()	()	ANTIHISTAMINES OR		
DRUGS			ANTICOAGULANTS			DECONG ESTANTS		
HIGH BLOOD PRE. MEDS.	()	()	(BLOOD THINNERS)	()	()	ASPIRIN AND HOW MUCH		
TRANQUILIZERS (VALIUM)	()	()	STEROIDS (CORTIZONE ETC)	()	()	DAILY_______________	()	()
HEART MEDICATION	()	()	INSULIN OR SIMILAR MEDS.	()	()	STOMACH MEDICATION	()	()

ARE YOU TAKING ANY OTHER REGULAR MEDICATIONS, IFYES, PLEASE LIST:

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____
____
____

ARE YOU ALLERGIC TO THE FOLLOWING MEDICATION OR EVER HAD A BAD REACTION TO:

	Y	N		Y	N		Y	N
LOCAL ANESTHESIA	()	()	CODEINE OR OTHER	()	()	ASPIRIN, IBUPROFEN	()	()
AMOXICILLIN/PENICILLIN	()	()	PAIN MEDICATION	()	()	LATEX OR OTHER RUBBER		
ERYTHROMYCIN	()	()	BARBITURATES,			PRODUCTS	()	()
CEPHALOSPORINS	()	()	SEDATIVES, ETC.	()	()			

OTHER ALLERGIES OR REACTIONS TO ANY REGULAR MEDICATIONS PLEASE LIST:

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PLEASE ANSWER ALL QUESTIONS BY MARKING EACH LINE YES OR NO: Y N

HAVE YOU HAD ANY SERIOUS ILLNESSES, OPERATIONS OR HOSPITALIZATION? () ()
IF YES DESCRIBE:

	Y	N		Y	N
DO YOU SMOKE?	()	()	ARE YOU O NA DIET?	()	()

DO YOU HAVE ANY OTHER DISEASE OR CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK THE DOCTOR SHOULD KNOW? Y () N ()

DO YOU WISH TO TALK TO THE DOCTOR PRIVATEL? Y () N ()
DATE OF YOUR LAST PHYSICAL EXAM? _________

DO YOU HAVE AID? Y () N ()
ARE YOU HIV + Y () N ()

THESE QUESTIONS ARE FOR YOUR SAFETY: Y N

RADIATION TREATMENT FOR CANCER? () ()
DO YOU HAVE AN IMMUNCSUPPRESIVE DISEASE? () ()
DO YOU HAVE HEPATITIS, IF SO WHAT TYPE (TYPE A, B, C)? () ()
DO YOU HAVE A DRUG OR ALCOHOL PROBLEM?

ARE YOU NOW OR HA'IE YOU EVER USED MARIJUANA OR STREET DRUGS? Y () N ()
DO YOU HAVE RECURRENT INFECTIONS OF ANY KIND? Y() N()

THIS SECTION IS FOR WOMAN ONLY:

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	Y	N
DO YOU TAKE BIRTH CONTROL PILLS?	()	()

PLEASE NOTE: IF YOU ARE USING ORAL CONTRACEPTIVES, IT IS IMPORTANT THAT YOU UNDERSTAND THAT ANTIBIOTICS AND OTHER MEDICATIONS MAY INTERFERE WITH THE EFFECTIVENESS OF ORAL CONTRACEPTIVES. THEREFORE, YOU WILL NEED TO USE MECHANICAL FORMS OF BIRTH CONTROL FOR ONE COMPLETE CYCLE OF BIRTH CONTROL PILLS AFTER THE COURSE OF ANTIBIOTICS OR OTHER MEDICATION IS COMPLETED. PLEASE CONSULT WITH YOUR PHYSICIAN FOR FURTHER GUIDANCE.

ARE YOU PREGNANT? YES () NO () IF YOU MARKED YES, HOW MANY MONTHS?_________________________

IF YOU ARE PREGNANT, POSSIBLY PREGNANT OR TRYING TO BECOME PREGNANT, SURGERY, ANESTHETICS OR ANY OTHER MEDICATION MAY SIGNIFICANTLY HARM YOUR DEVELOPING BABY, ESPECIALLY DURING THE FIRSTTRIMESTER, PLEASE ADVISE YOUR DOCTOR IF THERE ARE ANY CHANCE OF YOUR BEING PREGNANT.

WOULD YOU LIKE A PREGNANCY TEST? YES () NO ()

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I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

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SIGNATURE OF PERSON COMPLETING HEALTH HISTORY DOCTORS INITIALS DATE

DO YOU REQUIRE ANY SPECIAL ACCOMMODATIONS?

MENTAL? (Y) ______ (N) ______
PHYSICAL (Y) ______ (N)______