Medical History for New Patient

To help us provide the best care, please answer all questions on this form. Answers are confidential.

Last Name: ____________________ First Name: ____________________ Birthdate: ______________

Name of Medical Doctor ______________________________ City/State: ____________________

Emergency Contact ____________________ Phone ______________ Relationship ______________

List all Medications that you take:

If you take no medications, type 'None'

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________
13. ______________________________
14. ______________________________
15. ______________________________

Are you allergic to anything? Yes No

Please mark whether you have the following allergies.

Y	N	
		Local Anesthetics
		Aspirin
		Codeine
		Ibuprofen, naproxen or NSAID
		Iodine
		Latex
		Penicillin or Amoxicillin
		Sulfa
		Tetracycline
		Keflex or other Cephalosporins
		Other Drug Allergies
		Other Food or Environmental Allergies

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Do you have any of the following medical conditions? Yes No

Y	N		Y	N	
		Asthma			Kidney Disease, Kidney Failure or Dialysis
		Bleeding Problems			Alcohol/ Drug Abuse
		Cancer			Multiple Sclerosis
		Diabetes			Hepatitis/Liver Disease
		Heart Trouble			Sinus Trouble
		Chemotherapy/Radiation Treatment			Stroke
		High Blood Pressure			Ulcers
		Glaucoma			Tuberculosis
		Artificial Heart Valves			Sleep Apnea or gasping for air when sleeping
		AIDS + /HIV/ARC			High Cholesterol
		COPD or other Lung Disease			Thyroid Disease
		Smoke/ use Tobacco products			Parkinson/Epilepsy/Seizures
		Joint Replacement			Arthritis/ Rheumatism
		Pacemaker or Defibrillator			Osteoporosis
		Alzheimer's			Psychiatric Care/ Treatment
		Pregnant/ Could Possibly be/ Nursing			Gastric Reflux
					Other Health Problems

Other health problems? ____

Date: ____________

Signature: ____