Patient Medical History

Patient's Name: _____

Physicians Name: _____ **Physicians Phone Number:** _____

Gender

- ☐ Male
- ☐ Female

If Female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are You Pregnant? # of weeks? ☐
☐	☐	Are you nursing?

Y	N	
☐	☐	Do you smoke or use tobacco?

Height	
Weight	
Current Physical	

Y	N	
☐	☐	Current Medical Treatment
☐	☐	History of Hospital Admissions
☐	☐	Heart Disease
☐	☐	High Cholesterol
☐	☐	Heart Stent
☐	☐	Heart Valve Disease
☐	☐	Stroke
☐	☐	Arthritis
☐	☐	High Blood Pressure
☐	☐	Artificial Joint
☐	☐	Cancer/Tumor
☐	☐	Osteoporosis or Decreased Bone Density
☐	☐	Radiation or Chemotherapy
☐	☐	Thyroid Disease
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Digestive Problems
☐	☐	Bleeding Disorder
☐	☐	Neurologic Disorders
☐	☐	Allergies
☐	☐	Sinus Problems
☐	☐	Resporatory illnesses

Y	N	
☐	☐	Asthma
☐	☐	Sleep Apnea
☐	☐	CPAP/BiPAP
☐	☐	Snoring
☐	☐	Sleepiness/Fatigue
☐	☐	Epilepsy/ Seizures
☐	☐	Fainting/ Dizziness
☐	☐	Psychiatric Problems
☐	☐	Frequent Headaches
☐	☐	Tuberculosis
☐	☐	Hepatitis
☐	☐	HIV
☐	☐	Sexually Transmitted Disease
☐	☐	Diabetes
☐	☐	Frequent Urination
☐	☐	Unusual Thirst
☐	☐	Family History of Diabetes
☐	☐	Alcohol Use
☐	☐	Tobacco Use
☐	☐	Recreational Use of Drugs
☐	☐	Vitamins/OTC/Supplements
☐	☐	Consumption of Grapefruit Products
☐	☐	Sodas/Sports Drink Use

Please Explain All "Y" Answers In "Notes" Section Below

Y	N	**Allergies**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Medications:

Y **N** Is there any disease, condition, or problem that you think this office should know about that is not covered above?

If yes, please describe below

Notes:

Signature: _____ **Date:**

Doctors Signature: _____ **Date:**