CONFIDENTIAL MEDICAL HISTORY FORM – Please indicate corrections.

LAST NAME:____________________ FIRST NAME:_________________

MIDDLE NAME:__________________ PREFERRED NAME:______________

HOME ADDRESS:_________________ Zip Code:____________________

HOME: ( ) _________ Employer:________________ SS NO: ____-____-______

DOB: / / _____ WORK #:__________________ CELL #:_____________

REFERRING DOCTOR:____________________________ SEX:_______________

MARITAL STATUS:____________________ SPOUSE'S NAME:________________

MEDICAL ALERTS:____________________ EMAIL ADDRESS:_________________

MEDICAL HISTORY:
Date of Last Physical Exam:

Are you now or have your recently been under a physician's care?
Yes___No___
Reason:

Have you ever been a patient in a hospital or had any other serious illness?
Explain:

Check any of the following that you have had or suspected:

Yes	No		Yes	No		Yes	No	
__	__	Arthritis	__	__	Hepatitis or Jaundice	__	__	Prolonged Bleeding
__	__	Rheumatic Fever	__	__	Liver Disease	__	__	Fainting Tendency
__	__	Heart Trouble	__	__	Cancer or Tumor	__	__	Epilepsy
__	__	Heart Murmur	__	__	Tuberculosis	__	__	Thyroid Disease
__	__	High/Low Blood Pressure	__	__	Diabetes	__	__	Glaucoma
__	__	Chest Pain	__	__	Kidney/Bladder Trouble	__	__	Tradition Treatment
__	__	Stroke	__	__	Anemia	__	__	Mental Disorders
__	__	Shortness of Breath	__	__	Lung Disease	__	__	HIV or AIDS
__	__	Asthma or Hay Fever	__	__	Venereal Disease	__	__	Prosthetic Joint Replacement
__	__	Sinus Trouble	__	__	Blood Disease	__	__	Blood Transfusion

Check any of the following that you are taking or have taken:

__ Cortisone Drugs
__ Steroids
__ Anticoagulants
__ Blood Thinners
__ Tranquilizers
__ Sedatives

Are you taking any other medication? __ Yes __ No If yes, explain:

Are you allergic to or do you suffer ill side effects from any of the

following?

__ Penicillin	__ Codeine	__ Dental Anesthetics	__ Latex
__ Aspirin	__ Household Bleach	__ Other	__ None known

The above information is true to the best of my knowledge.

Responsible party for patient:

Name and Address: ____

Signature: ____**Date:**_________