PATIENT MEDICAL HISTORY

1. How would you describe your current health status ? Excellent Good Fair Poor
2. List your physician(s) and any conditions you are being treated for:

Dr. _____ Treating you for _____ How long _____Dr. _____ Treating you for _____ How long _____

Dr. _____ Treating you for _____ How long _____

3. Date of last physical examination _____ Purpose _____ Findings _____
4. List ALL medicines or nutritional supplements, including over the counter medicine, you are currently taking :

_____

_____

Circle "Yes" or "No"		Explain or list
5. Are you on a special or restricted diet of any kind?	No	Yes_____
6. Are you allergic to any medications?	No	Yes_____
7. Do you smoke or use tobacco in any form?	No	Yes_____
How long _____		
8. Have you been hospitalized within the past 2 years?	No	Yes_____
9. If female, Are you pregnant or taking birth control pills?	No	Yes _____
10. Do you have more than one alcoholic drink a day?	No	Yes_____
11.Has your health changed in the last 12 months?	No	Yes_____

Indicate (check) which of the following conditions you have ever had or been treated for:

___ Heart disease or attack*_____ ___ Kidney problems* _____

___ Heart trouble* _____ ___ Emphysema* _____

___ Pacemaker*_____ ___ COPD*_____ ___ Artificial Heart valve*_____ ___ Asthma*_____

___ Excessive bleeding*_____ ___ Tuberculsosis*_____

___ High blood pressure* _____ ___Diabetes*_____ ___ Stroke* _____ ___Epilepsy or seizures*_____

___ Anemia*_____ ___Cancer or tumor*_____

AIDS* _____ ___Radiation therapy*_____

___ Drug or alcohol addiction* _____ ___Arthritis*_____

___ Psychiatric care* _____ ___Ulcers*_____

___ Artificial joint* _____ ___Venereal disease*_____

___ Glaucoma* _____ ___Liver disease*_____

___ Contact lenses* _____ ___Hepatitis*_____

Explain ANY health problems not listed above? _____

By signing below I certify that to the best of my knowledge, all of the above answers are true and correct. If I ever have any changes in my health, I will inform the doctor or office before my next visit.

Signature of Patient, Parent, or Guardian _____ Date _____