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 all Yes answers**
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? How long _____	No	Yes_____
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*_____
___ Heart trouble*_____
___ Pacemaker*_____
___ Artificial Heart valve*_____
___ Excessive bleeding*_____
___ High blood pressure* _____
___ Stroke* _____
___ Anemia*_____
___AIDS* _____
___ Drug or alcohol addiction* _____
___ Psychiatric care* _____
___ Artificial joint* _____
___ Glaucoma* _____
___ Contact lenses* _____

___ Kidney problems*_____
___ Emphysema*_____
___ COPD*_____
___ Asthma*_____
___ Tuberculosis*_____
___Diabetes*_____
___Epilepsy or seizures*_____
___Cancer or tumor*_____
___Radiation therapy*_____
___Arthritis*_____
___Ulcers*_____
___Venereal disease*_____
___Liver disease*_____
___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 _____