

PATIENT MEDICAL HISTORY

Patients Name:		Today's Date	Date of Last Visit:
Address:			
City, State, Zip:		Email:	
Home Phone:	Work Phone:	Cell Phone:	
Birth Date:	Marital Status:	Social Security No:	
Physician's Name:		Physician's Phone:	
Pharmacy:		Pharmacy Phone:	

Any medical diagnoses or surgeries in the past 6 months:

Sex:	If Female, please answer the following:	Please answer the following:	
<input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/> Are you taking Birth Control Pills? <input type="checkbox"/> <input type="checkbox"/> Are you pregnant? If Yes, # of weeks _____ <input type="checkbox"/> <input type="checkbox"/> Are you nursing	Y N <input type="checkbox"/> <input type="checkbox"/> Do you smoke or use Tobacco? How much? _____	Height: <input style="width: 40px;" type="text"/> Weight: <input style="width: 40px;" type="text"/>

Y N CONDITIONS <input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> <input type="checkbox"/> Allergic to Bleach <input type="checkbox"/> <input type="checkbox"/> Allergies <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> Artificial Bones or Joints-what? _____ <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve-when? _____ <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion-when? _____ <input type="checkbox"/> <input type="checkbox"/> Bruise Easily <input type="checkbox"/> <input type="checkbox"/> Cancer – Chemotherapy-when? _____ <input type="checkbox"/> <input type="checkbox"/> Cancer – No Chemotherapy <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect <input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> <input type="checkbox"/> Drug Abuse <input type="checkbox"/> <input type="checkbox"/> Drug Abuse – History of <input type="checkbox"/> <input type="checkbox"/> Emphysema <input type="checkbox"/> <input type="checkbox"/> Epilepsy <input type="checkbox"/> <input type="checkbox"/> Fainting Spells <input type="checkbox"/> <input type="checkbox"/> Fever Blisters	Y N CONDITIONS <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> HIV + Aids <input type="checkbox"/> <input type="checkbox"/> Heart Attack-when? _____ <input type="checkbox"/> <input type="checkbox"/> Heart Murmur <input type="checkbox"/> <input type="checkbox"/> Heart Problems-what? _____ <input type="checkbox"/> <input type="checkbox"/> Hemophilia <input type="checkbox"/> <input type="checkbox"/> Hepatitis-which form? _____ <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Kidney Problems <input type="checkbox"/> <input type="checkbox"/> Liver Disease <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> <input type="checkbox"/> Pace Maker <input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joints <input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy-when? _____ <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> <input type="checkbox"/> Seizures <input type="checkbox"/> <input type="checkbox"/> Shingles <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> <input type="checkbox"/> Sinus Problems <input type="checkbox"/> <input type="checkbox"/> Stroke-when? _____	Y N CONDITIONS <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> <input type="checkbox"/> Venereal Disease <input type="checkbox"/> <input type="checkbox"/> Osteoporosis <input type="checkbox"/> <input type="checkbox"/> Taken Fen-Phen <input type="checkbox"/> <input type="checkbox"/> Endocarditis-when? _____ ALLERGIES Y N <input type="checkbox"/> <input type="checkbox"/> Aspirin <input type="checkbox"/> <input type="checkbox"/> Codeine <input type="checkbox"/> <input type="checkbox"/> Dental Anesthetics <input type="checkbox"/> <input type="checkbox"/> Erythromycin <input type="checkbox"/> <input type="checkbox"/> Jewelry <input type="checkbox"/> <input type="checkbox"/> Latex <input type="checkbox"/> <input type="checkbox"/> Metals <input type="checkbox"/> <input type="checkbox"/> Penicillin <input type="checkbox"/> <input type="checkbox"/> Amoxicillin <input type="checkbox"/> <input type="checkbox"/> Tetracycline Other: _____ _____ _____
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Y N

Prescription or Over the Counter Medications and/or supplements:

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:

Y N

Have you ever taken any of the following medications? They are commonly used for conditions such as cancer (chemotherapy), osteoporosis and/or arthritis. If yes, please mark below:

Orally administered	bisphosphonates	Dates started	Dates stopped
Brand Name	Generic Name		
Actonel	risedronate		
Boniva	ibandronate		
Fosamax	alendronate		
Fosamax Plus D	alendronate		
Skelid	tiludronate		
Didronel	etidronate		
Intravenously administered	bisphosphonates	Dates started	Dates stopped
Brand Name	Generic Name		
Aredia	pamidronate		
Zometa	zoledronic acid		
Bonefos	clodronate		
Didronel	etidronate		
Reclast for Osteoporosis	zoledronic acid		

Signature: _____ Date: _____

(If under 18, Parent of Guardian Signature Required)