Medical Health History

PATIENT NAME:____ DATE:____________________

Email:___________________________ Cell Phone #___________________________

MEDICAL DOCTOR________________________ OFFICE PHONE_____________ DATE OF LAST EXAM_______________

	Question	Yes	No
1.	Are you under medical treatment now?	❑	❑
2.	Have you ever been hospitalized for any surgical operation or serious illness?	❑	❑
3.	Are you taking any medication(s) including non-prescription medicine? If yes, please list medication: ___________________ _____________________________________	❑	❑
4.	Do you use tobacco?	❑	❑
5.	Do you use alcohol, cocaine, or other drugs?	❑	❑
6.	Are you wearing contact lenses?	❑	❑

7. Are you allergic to or have you had any reactions to the following?:

Yes	No		Yes	No	
❑	❑	Local anesthetics	❑	❑	Barbiturate
❑	❑	Penicillin/antibiotics	❑	❑	Sedatives
❑	❑	Aspirin	❑	❑	Sulfa drugs
❑	❑	Iodine	❑	❑	Other

8. WOMEN ONLY:

	Yes	No
Are you pregnant or think you may be?	❑	❑
Are you nursing?	❑	❑
Are you taking birth control pills?	❑	❑

9. Do you have or have you had any of the following?

Yes	No		Yes	No		Yes	No	
❑	❑	High Blood Pressure	❑	❑	Fainting/Seizures	❑	❑	Arthritis
❑	❑	Heart Disease	❑	❑	Frequently Tired	❑	❑	Liver Disease
❑	❑	Chest Pains	❑	❑	Tuberculosis	❑	❑	Hepatitis/Jaundice
❑	❑	Heart Attack	❑	❑	Asthma	❑	❑	Kidney Disease
❑	❑	Cardiac Pacemaker	❑	❑	Respiratory Problems	❑	❑	Thyroid Problem
❑	❑	Easily Winded	❑	❑	Emphysema	❑	❑	Stomach Trouble/Ulcer
❑	❑	Rheumatic Fever	❑	❑	Anemia	❑	❑	Gastric Reflux
❑	❑	Heart Murmur	❑	❑	Radiation Therapy	❑	❑	AIDS or HIV Infection
❑	❑	Stroke	❑	❑	Low Blood Pressure	❑	❑	STD's
❑	❑	Swollen Ankles	❑	❑	Glaucoma	❑	❑	Diabetes
❑	❑	Angina	❑	❑	Leukemia	❑	❑	Artificial Joints
❑	❑	Hay Fever/Allergies	❑	❑	Cancer	❑	❑	Other__________________
❑	❑	Snoring/Sleep Apnea	❑	❑	Do you use a CPAP device			

COMMENTS: ____

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I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health.

SIGNATURE ____

PATIENT, PARENT, OR GUARDIAN DATE