PATIENT MEDICAL HISTORY

Patient's Medical History

Physician Information

Physician's Full Name: _____

City, State, Zip Code: _____

Are you currently under a Physician's Care? Yes No

If yes, for what? _____

Have you been hospitalized in the last two years? Yes No

If yes, for what? _____

Are you taking any medications, drugs, or pills? Yes No

If so, Please list the names and dosages of each_____

Do you smoke? Yes No How Much? _____

Women Only

Are you pregnant? Yes No Are you taking birth control pills? Yes No

Are you nursing? Yes No Are you on hormone therapy? Yes No

Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

Allergic to Penicillin	**Allergic to Codeine**	**Pre-Medication required**	**Pacemaker**
Allergic to Tetracycline	**Allergic to Novocain**	**Mitral Valve Prolapse**	**HIV Positive**
Allergic to Aspirin	**Allergic to Latex Rubber**	**Heart Problems**	**Prior Hepatitis**

Other:

_____

Please Circle all that applies

Medical Conditions

Heart Attack
Heart Murmur
Chest Pain
Congenital Heart Problem
Artificial Heart Valve
Heart Surgery
High/Low Blood Pressure
Rheumatic Fever
Anemia
Blood Disease
Blood Transfusion
Stroke
Deep Vein Clot
Hemophilia

Excessive Bleeding
Sickle Cell Disease
Glaucoma
Diabetes
Excessive Thirst
Scarlet Fever
Thyroid Disease
Parathyroid Disease
Kidney Disease
Liver Disease
Hepatitis A or B
Yellow Jaundice
Cancer
X-Ray or Cobalt Treatment

Chemotherapy
Ulcers
Gastrointestinal Upset
Acid Reflux
Lung Disease
Tuberculosis
Shortness of Breath
Emphysema
Asthma
Sinus Trouble
Hay Fever
Frequent Cough
Rheumatism
Arthritis/Gout

Osteoporosis
Swelling of Feet/Ankles
Artificial Joint Replacement
Psychiatric Care
Epilepsy or Seizures
Extreme Nervousness
Fainting or Dizziness
Hypoglycemia
Hives
Cold Sores/Fever Blisters
Venereal Disease
Herpes
Cortisone Treatment
Chemical Dependency

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

**** PLEASE BE ADVISED ALL PAYMENTS ARE NON-REFUNDABLE & WE ONLY ACCEPT CASH AND CREDIT, NO CHECKS****

Signature: _____

Date: _____

Witness: _____