MEDICAL HISTORY

Patient Name _____DOB: _____

Primary Care Physician: _____PCP tel#_____

Are you currently taking any medications? ____Y or ____ N
If yes, please list names/doses:
_____
_____

Please check any **allergies** that apply: ___ Aspirin ___Codeine ___Dental Anesthetics
___ Erythromycin ___ Jewelry ___ Latex ___ Metals ____Tetracycline ___ Penicillin
Other: _____

Conditions: Check any that apply:

___ Abnormal Bleeding	___ Epilepsy	___ Pain In Jaw Joints
___ Alcohol Abuse	___ Fainting Spells	___ Pneumocystitis
___ Allergies	___ Fever Blisters	___ Psychiatric Care
___ Anemia	___ Frequent Headaches	___ Radiation Therapy
___ Angina	___ Glaucoma	___ Rheumatic Fever
___ Arthritis	___ HIV+/AIDS	___ Seizures
___ Artificial bones/joints	___ Hay Fever	___ Shingles
___ Artificial Heart Valve	___ Heart Attack	___ Sickle Cell Disease
___ Asthma	___ Heart Murmur	___ Sinus Problems
___ Blood transfusion	___ Heart Surgery	___ Stroke
___ Bruise easily	___ Hemophilia	___ Thyroid Problems
___ Cancer/Chemo	___ Hepatitis-(Type)___	___ Tuberculosis
___ Colitis	___ High Blood Pressure	___ Ulcers
___ Congenital Heart Defect	___ Kidney Problems	___ Venereal Disease
___ Cosmetic Surgery	___ Liver Disease	___ Yellow Jaundice
___ Diabetes	___ Low Blood Pressure	___ **Other**:_____
___ Difficulty breathing	___ MVP	_____
___ Drug Abuse	___ Night Sweats	_____
___ Emphysema	___ Pace Maker	_____

Do you smoke? Y or N Do you use tobacco? Y or N

WOMEN: Are you currently: taking birth control____pregnant____(#wks____) nursing____?

Pharmacy: _____Telephone # _____

Signature: _____ **Date:** _____