



# PATIENT MEDICAL HISTORY

Patient's Name: \_\_\_\_\_ Best Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Patient Mailing/Billing address: \_\_\_\_\_

*Street*

*City*

*Zip code*

Patient email address: \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Pharmacy phone: \_\_\_\_\_

Please list any Medications you are currently taking: \_\_\_\_\_

Are you currently undergoing any type of medical treatment? \_\_\_\_\_

Have you had any major operations? If yes, what kind? \_\_\_\_\_

Do you smoke or use tobacco? \_\_\_\_\_ Packs per day? \_\_\_\_\_

Do you currently take Aspirin on daily basis? \_\_\_\_\_

If female: Are you taking Birth Control Pills? \_\_\_\_\_ Are you or could you be pregnant? \_\_\_\_\_

Please check box for all that apply:

<u>Conditions</u>	<u>Conditions</u>	<u>Conditions</u>
<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Arthritis,	<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Hemophilia	Osteo/Rheumatoid	<input type="checkbox"/> Donor Organs
<input type="checkbox"/> Alcohol Abuse	Osteoporosis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Hepatitis A, B, C	<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Allergies	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Fainting Spells
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Pain In Jaw Joints	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Cancer/Chemotherapy	<input type="checkbox"/> Stroke
<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Glaucoma
	<input type="checkbox"/> Heart Defect	

<input type="checkbox"/> Liver Disease <input type="checkbox"/> Nervous Problems or Disorders <input type="checkbox"/> Artificial Heart Valve/Stents/Shunts <input type="checkbox"/> Seizures <input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Diabetes <input type="checkbox"/> Recreational Drugs <input type="checkbox"/> Sexually Transmitted Diseases <input type="checkbox"/> Shingles	<input type="checkbox"/> Thyroid Problems <input type="checkbox"/> HIV +AIDS <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Heart Attack <input type="checkbox"/> Tumors or Growths <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Ulcers
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Please check box for yes:

<p style="text-align: center;"><u>Allergies</u></p> <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Dental Anesthetics <input type="checkbox"/> Erythromycin <input type="checkbox"/> Jewelry <input type="checkbox"/> Latex <input type="checkbox"/> Metals <input type="checkbox"/> Penicillin <input type="checkbox"/> Tetracycline  Other: _____	<p style="text-align: center;"><u>Have you ever taken any of the following medication?</u></p> <input type="checkbox"/> Aredia <input type="checkbox"/> Actonel <input type="checkbox"/> Boniva <input type="checkbox"/> Fosamax <input type="checkbox"/> Zometa <input type="checkbox"/> Any other Meds for Bone Density? If yes, what: _____
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Is there any disease, condition or problem that you think the doctor should know about that is not covered above? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If under age 18, Parent or Guardian Signature Required

Dr. Signature: \_\_\_\_\_ Date: \_\_\_\_\_