PATIENT MEDICAL HISTORY FORM
Please complete all fields

Name:____ Date:_________________________
Age:________ Date of Birth: ___/____/___________ Height: _________ Weight:________________
Primary Care Physician:___________________________________ Phone Number:_____________________
Physician's Address:____

LIST CURRENT MEDICATIONS & DOSES: (Please include Vitamins & Supplements)

PRESENT ILLNESSES:			**DESCRIBE:**
Do you have any heart disease, heart trouble or heart abnormality?	Y	N	_______________
Do you have high blood pressure?	Y	N	_______________
Do you have a cold?	Y	N	_______________
Any recent or long term problems with your lungs?	Y	N	_______________
Have you had jaundice, hepatitis, or liver trouble?	Y	N	_______________
Do you have diabetes?	Y	N	_______________
Do you have thyroid trouble?	Y	N	_______________
Do you have kidney trouble?	Y	N	_______________
Have you had back pain or injury?	Y	N	_______________
Do you have other illnesses?	Y	N	_______________

IS THERE A FAMILY HISTORY OF:			
Cancer ?	Y	N	_______________
Diabetes?	Y	N	_______________
Bleeding Tendency?	Y	N	_______________
Arthritis?	Y	N	_______________
Heart Disease?	Y	N	_______________
Hypertension?	Y	N	_______________

PERSONAL & SOCIAL:			
Do you smoke? If yes, how much and for how long?	Y	N	_______________
Do you drink alcohol? If yes, how much?	Y	N	_______________
Any loose, capped, or false teeth?	Y	N	_______________

SURGERIES:
Any previous surgeries? When? Results? Please Describe:_____________________________________
____
____
What type of anesthesia was used?____

ALLERGIES:
Do you have any allergies to medicine? Please describe:______________________________________
____
Any unusual reactions to anesthesia by you or a family member? Please describe:_______________
____

TEST RESULTS:
Have you had an x-rays of this injury? Y N Did you bring them? Y N Location:__________________
Have you had a recent EKG? Results?____ Date:__________
Have you had a recent MRI? Results?____ Date:__________