Patient Information and Medical History Update

Patient Name_____ **Date of Birth**_____

Home Address _____**City** _____**State** _____**Zip** _____

Home Phone # _____**Work Phone#** _____**Cell Phone #** _____

Employer_____ **Insurance Company**_____ **Member #**_____

PHYSICIAN _____ **OFFICE PHONE** _____ **LAST EXAM**_____

(Please place an X in the box which applies) ✗

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, what medications are you taking? _____
   _____
   _____
4. Do you use Tobacco? Packs a day? _____ ☐
5. Do you use alcohol, cocaine or other drugs? ☐

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

✗	
☐	Local Anesthetics
☐	Penicillin
☐	Antibiotics
☐	Aspirin
☐	Sedatives

7. Other food or drug allergies? If so, what?

_____

8. Women Only:

	✗
a) Are you pregnant or think you may be pregnant?	☐
b) Are you nursing?	☐
c) Are you taking birth control?	☐

9. Preferred Pharmacy: _____

10. Do you have or have you had any of the following? (Please place an X in the box which applies)

✗		✗		✗		
☐	**High Blood Pressure**	☐	**Frequently Tired**	☐	**Hepatitis**	**COMMENTS**
☐	**Heart Attack**	☐	**COPD**	☐	**Jaundice**	
☐	**Heart Disease**	☐	**Tuberculosis**	☐	**Thyroid Problem**	
☐	**Cardiac Pacemaker**	☐	**Respiratory Problems**	☐	**Swollen Ankles**	
☐	**Angina**	☐	**Fainting / Seizures**	☐	**Arthritis**	
☐	**Chest Pains**	☐	**Epilepsy / Convulsions**	☐	**Joint Replacement or Implant**	
☐	**Stroke**	☐	**Diabetes**	☐	**Sexually Transmitted Disease**	
☐	**Anemia**	☐	**Kidney Disease**	☐	**Stomach Troubles / Ulcers**	
☐	**Asthma**	☐	**Cancer**	☐	**Glaucoma**	
☐	**Emphysema**	☐	**Radiation Therapy**	☐	**Sleep Apnea**	
☐	**Easily Winded**	☐	**Liver Disease**	☐	**Other** _____	

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 information can be dangerous to my health.

Signature: _____ Date_____

(Patient, Parent or Guardian)