

Medical History

Last Name _____ First Name _____ MI _____

Reason for today's visit? _____

Height _____ Weight _____ Age _____

Currently under the care of a physician? YES NO Name of MD _____

For what reason? _____

Please circle one:

Heart disease	YES	NO	Fainting	YES	NO
Cancer	YES	NO	Diabetes	YES	NO
HIV/AIDS	YES	NO	Tuberculosis	YES	NO
Hepatitis	YES	NO	Hemophilia	YES	NO
Anemia	YES	NO	Blood Transfusion	YES	NO
High blood pressure	YES	NO	Low blood pressure	YES	NO
Artificial joints	YES	NO	Kidney problems	YES	NO
Asthma	YES	NO	Difficulty breathing	YES	NO
Headaches	YES	NO	Emphysema	YES	NO
Herpes	YES	NO	Shingles	YES	NO
Psychiatric problems	YES	NO	Pace Maker	YES	NO

Do you smoke? YES NO How much? _____

Do you consume alcohol? YES NO How much? _____

Allergies? YES NO Please list: _____

Please list all surgeries you have had and their dates: _____

Are you currently taking any medications? YES NO Please list: _____

Are subject to excessive bleeding when cut? YES NO

Are subject to overgrown scars or keloids? YES NO

Are you subject to difficult wound healing? YES NO

Women only:

Birth control pills? YES NO

Last PAP Smear date _____ Last mammogram _____

Number of pregnancies/births: _____/

_____/_____
Signature of Patient or Guardian Date

Who may we thank for referring you to our office? _____