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Patient Name: **Birthdate:** _______________ **Entry Date:** _______________

Medical Health History

How is your general health? ______________________________

Date of last physical examination ____________ Findings ______________________________

	Yes	No
Are you being treated by a physician or psychiatrist now?	☐	☐
Are you taking any medications or supplements? (prescription or over the counter)	☐	☐

(Please mark all that apply. List name of drug & dosage on following page)

☐ Antibiotics ☐ Anticoagulants (blood thinners) ☐ Herbal medication ☐ Aspirin
☐ Insulin ☐ Blood pressure medicine ☐ Cortisone (steroids) ☐ Pain medicine
☐ Hormones or contraceptives ☐ Heart medicine ☐ Other ______________________

	Yes	No
Have you ever had any serious illness that required hospitalization?	☐	☐
Are you on a special diet?	☐	☐
Do you have heart trouble?	☐	☐

☐ Congestive heart failure ☐ Chest pains on examination ☐ Heart murmur
☐ Heart attack ☐ High or low blood pressure ☐ Other heart trouble ______________________

	Yes	No
Have you had a serious infectious disease?	☐	☐

☐ Hepatitis ☐ Tuberculosis ☐ Sexually transmitted disease ☐ AIDS / HIV ☐ Other disease ______________

	Yes	No
Have you had any of the following?	☐	☐

☐ Liver disorder ☐ Diabetes ☐ X-ray therapy ☐ Tension
☐ Kidney disorder ☐ Arthritis ☐ Periods of depression ☐ Epilepsy
☐ Lung problems ☐ Anemia ☐ Frequent headaches ☐ Ulcer
☐ Cancer or tumor ☐ Glaucoma ☐ Fainting or dizziness ☐ Thyroid problems (goiter)

	Yes	No
Have you had abnormal bleeding associated with extractions, surgery, injury or menstruation?	☐	☐
Have you ever had a blood transfusion?	☐	☐
Are you allergic to any drugs or have you experienced an unusual reaction to any drug?	☐	☐

☐ Dental anesthetic ☐ Penicillin ☐ Barbiturates or sedatives
☐ Codeine ☐ Sulfa drugs ☐ Latex (rubber gloves)
☐ Aspirin ☐ Other antibiotics ☐ Other drug ______________________

Medical Health History Continued

	Yes	No
Do you have any allergic condition?	☐	☐
☐ Asthma ☐ Skin rashes ☐ Sinus problems		
☐ Hay fever ☐ Other condition ____________		
Do you smoke?	☐	☐
Packs per day ______ # of years ______		
Do you use chewing tobacco?	☐	☐
Do you drink coffee daily?	☐	☐
How much? ____________		
Do you drink alcoholic beverages daily?	☐	☐
Do you use cocaine, marijuana or other mind altering drugs?	☐	☐
Is there a tendency towards any illness in your family?	☐	☐
☐ Diabetes ☐ Cancer ☐ Alcoholism ☐ Heart disease ☐ Other illness ____________		
Do you have any disease, condition or problem not listed that I should know about?	☐	☐
Explain: ____________		
Women: Is there a possibility you are pregnant or are you nursing a child?	☐	☐

Use this box for details on medications and for any additional comments

Signature of patient, parent or guardian

x ____________________

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Signer's Full Name

☐ ☐ ☐