MEDICAL HISTORY

Name: _____

Date and reason for last medical visit _____

Date of last physical exam: _____ Name and phone number of primary care physician: _____

_____

State of your general health (check one): ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Are you under the care of any medical specialists at this time? ☐ Yes ☐ No

If yes, name and phone number _____

Are you currently taking any medications (including aspirin)? ☐ Yes ☐ No

If yes, please list: _____

Do you take any herbal or other non-prescription supplements? ☐ Yes ☐ No

If yes, please list _____

Have you ever had an allergic or adverse reaction to any medication(s)? ☐ Yes ☐ No

If yes, please list: _____

Are you allergic to any other substance <u>including latex</u>? ☐ Yes ☐ No

Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No

Have you ever taken prescription medication for bone density (Bisphosphates)? ☐ Yes ☐ No

Have you been a patient in the hospital in the past 5 years? ☐ Yes ☐ No

If yes, for what? _____

Women: Are you or could you be pregnant? ☐ Yes ☐ No

Check all of the following that you have had, or have now:

☐Y ☐N Heart: (surgery/disease/attack)
☐Y ☐N Chest pain
☐Y ☐N Heart murmur/Mitral valve prolapse
☐Y ☐N Rheumatic fever
☐Y ☐N Abnormal blood pressure: Hi/Lo
☐Y ☐N Diabetes
☐Y ☐N Kidney dysfunction/disease
☐Y ☐N Lung dysfunction/disease
☐Y ☐N Asthma
☐Y ☐N Psychiatric/mental disorder
☐Y ☐N Abnormal bleeding/blood disorder
☐Y ☐N Liver disease/Hepatitis
☐Y ☐N Tuberculosis
☐Y ☐N AIDS or HIV
☐Y ☐N Other infectious disease
☐Y ☐N Cancer/tumors
☐Y ☐N Stroke
☐Y ☐N Neurological disorder
☐Y ☐N Joint replacement
☐Y ☐N Cold sores/herpetic lesions
☐Y ☐N HPV Vaccine

Do you have any other medical condition(s) or problem(s) not listed on this form? ☐ Yes ☐ No If so, please list:

_____

Date: _____ **Signature:** _____

<u>Office use only</u>

Review and additional notes: _____

_____

Date and sign: _____