PATIENT MEDICAL HISTORY

NAME_____ **DATE**_____

Height _____ **Weight** _____
Are you currently under the care of or do you have an internist (Family Physician)? Yes _____ No _____, If yes, please give

Name of physician_____ **Address** _____ **Phone #**_____

Do you have or have had any of the following conditions?

High Blood Pressure	**YES** ____	**NO**____	**Chest Pain**	**YES** ____	**NO**____
Heart Murmur	**YES** ____	**NO**____	**Shortness of Breath**	**YES** ____	**NO**____
Irregular Heartbeat	**YES** ____	**NO**____	**Rheumatic Fever**	**YES** ____	**NO**____
Mitral Valve Prolapse	**YES** ____	**NO**____	**Ankle Swelling**	**YES** ____	**NO**____
Leg Pain	**YES** ____	**NO**____	**Pacemaker**	**YES** ____	**NO**____
Blood Clots in Legs	**YES** ____	**NO**____	**Heart Surgery**	**YES** ____	**NO**____
Heart Attack	**YES** ____	**NO**____	**Confusion**	**YES** ____	**NO**____
Stroke/TIA	**YES** ____	**NO**____	**Asthma**	**YES** ____	**NO**____
Joint Replacement	**YES** ____	**NO**____	**Pneumonia**	**YES** ____	**NO**____
Congestive Heart Failure	**YES** ____	**NO**____	**Emphysema**	**YES** ____	**NO**____
Chronic Cough	**YES** ____	**NO**____	**Positive TB Test**	**YES** ____	**NO**____
Tuberculosis	**YES** ____	**NO**____	**Abnormal Chest X-ray**	**YES** ____	**NO**____
Cancer (Type:_____)	**YES** ____	**NO**____	**Hepatitis**	**YES** ____	**NO**____
HIV	**YES** ____	**NO**____	**Bruising**	**YES** ____	**NO**____
Diabetes	**YES** ____	**NO**____	**Dizziness**	**YES** ____	**NO**____
Thyroid Disease	**YES** ____	**NO**____	**Head or Neck Injury**	**YES** ____	**NO**____
Seizures	**YES** ____	**NO**____	**Facial Injuries**	**YES** ____	**NO**____
Fainting	**YES** ____	**NO**____	**Numbness of Arms or Legs**	**YES** ____	**NO**____
Muscle Weakness	**YES** ____	**NO**____	**Migraine**	**YES** ____	**NO**____
Back Injury	**YES** ____	**NO**____	**Bleeding Problem**	**YES** ____	**NO**____
Broken Bones	**YES** ____	**NO**____	**Arthritis**	**YES** ____	**NO**____

☐ **Do you take prescription medications, over-the-counter medications? No _____Yes_____ If Yes, please list**

Medications **Dose** **How Often** **Reason**

_____

_____

_____

☐ **Did you ever take Fen-Fen/Redux? No _____Yes_____**
MAO Inhibitors? (Nardil (pheneizine), Pamate (tranylcypromine) No _____Yes_____ If Yes, please list

_____

_____

☐ **Do you take St. John's Wart? No _____Yes_____**
Homeopathic Medications? No _____Yes_____ If Yes, please list

_____

_____

☐ **Please list any allergies you have to any medications:**
Allergic to **What type of reaction?**

_____

_____

☐ **Are you allergic to Soybeans or Eggs? No _____Yes_____**

☐**Do you have skin allergies (ex. Adhesive tape, latex, steri-strips, and lotions)?**

_____

Do you smoke? If yes, how much? _____ **Do you drink alcohol? If yes, how much?**_____

Do you have any problems at a dentist's office? No _____Yes_____

Do you bleed excessively when cut? No _____Yes_____

Do you have difficulty with the healing of wounds? No _____Yes_____

Please list all previous surgeries

_____

_____

_____