

PATIENT INFORMATION (Please Print)

DATE: ____/____/____

NAME _____ MARRIED ___ SINGLE ___
Last First MI

ADDRESS _____
Street Apt# City State Zip

BIRTHDAY ____/____/____ TELEPHONE _____
Home# Work#

EMAIL ADDRESS _____ (PLEASE PRINT CLEARLY)

YOUR MEDICAL HISTORY

Your physician's name _____ Telephone # _____

Approximate date of last physical examination _____

Currently under care for _____

What medications, including oral contraceptives are you taking? _____

What ALLERGIES do you have? _____

Penicillin/Other Antibiotics? ___ Yes ___ No Latex? ___ Yes ___ No

Are you in good general health? _____

Are you a smoker? ___ Yes ___ No Are you now pregnant? ___ Yes ___ No

Are you nursing? ___ Yes ___ No

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- | | |
|---|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cancer/X-ray therapy |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> AIDS/HIV Positive |
| <input type="checkbox"/> Surgeries | <input type="checkbox"/> Artificial Joints/Valve |
| <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Hepatitis/Jaundice |
| <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Drug/Alcohol Treatment |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Nasal Obstruction | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Tuberculosis/Respiratory Disease |
| <input type="checkbox"/> Thyroid Abnormalities | <input type="checkbox"/> Nervousness |

SIGNATURE: _____