

**MEDICAL HISTORY FORM**

PATIENT'S NAME: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

**WHO IS YOUR PRIMARY CARE PHYSICIAN?**

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_  
 ( ) \_\_\_\_\_ - \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

**LIST ALL SERIOUS ILLNESSES FORMALLY DIAGNOSED BY A PHYSICIAN (INCLUDING THOSE YOU TAKE OR DO NOT TAKE MEDICATION FOR):**

MEDICAL CONDITION:	DATE DIAGNOSED:	NAME AND TELEPHONE NUMBER OF TREATING PHYSICIAN:
_____	_____	_____ ( ) _____ - _____
_____	_____	_____ ( ) _____ - _____
_____	_____	_____ ( ) _____ - _____
_____	_____	_____ ( ) _____ - _____
_____	_____	_____ ( ) _____ - _____

**LIST ALL MEDICATIONS YOU ARE TAKING (INCLUDING VITAMINS/SUPPLEMENT, ETC.)**

MEDICATION NAME:	FOR WHICH CONDITION?:	DOSE/INSTRUCTIONS:	PRESCRIBING M.D.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PLEASE CHECK "YES" OR "NO" TO THE FOLLOWING AND LIST ALL ALLERGIES YOU MAY HAVE OR SUSPECT YOU MAY HAVE:**

MEDICATIONS? YES  NO  \_\_\_\_\_  
 ANESTHETICS? YES  NO  \_\_\_\_\_  
 INJECTIONS? YES  NO  \_\_\_\_\_  
 LATEX RUBBER? YES  NO  \_\_\_\_\_  
 TAPE? YES  NO  \_\_\_\_\_  
 ENVIRONMENTAL? YES  NO  \_\_\_\_\_  
 FOOD? YES  NO  \_\_\_\_\_  
 OTHER: \_\_\_\_\_

**LIST ALL SURGERIES:**

TYPE OF SURGERY:	DATE PERFORMED:	NAME AND TELEPHONE NUMBER OF SURGEON:
_____	_____	_____ ( ) _____ - _____
_____	_____	_____ ( ) _____ - _____
_____	_____	_____ ( ) _____ - _____
_____	_____	_____ ( ) _____ - _____
_____	_____	_____ ( ) _____ - _____

HAVE YOU EVER HAD ANY BLOOD TRANSFUSIONS? YES  NO

HAVE YOU EVER HAD ANY BROKEN BONES? YES  NO

IF "YES," PLEASE LIST: \_\_\_\_\_

DO YOU SMOKE?: YES  NO  (IF YES, HOW OFTEN/HOW MUCH: \_\_\_\_\_)

**LIST ALL FAMILY MEDICAL HISTORY/ CONDITIONS KNOWN (HEREDITARY):**

MOTHER'S SIDE: \_\_\_\_\_ FATHER'S SIDE: \_\_\_\_\_

PLEASE LIST ANY ADDITIONAL MEDICAL INFORMATION WE SHOULD BE AWARE OF: