Medical History Update

Name _____ Date of Birth _____
Last First

Address _____
Street City Zip

Phone- Home _____ Work _____ Cell _____ E-Mail _____

---

1. Primary Physicians Name _____

   Address _____ Phone _____

2. When was your last complete physical exam? _____
3. Are you taking any medication or substances? _____ YES NO
   If so, please list _____
4. Are you currently taking any herbal or homeopathic remedies? _____ YES NO
   If so, please list _____
5. Are you allergic to any medications or substances? _____ YES NO
   If so, please list _____
6. Are you sensitive to any metals or latex? _____ YES NO
7. Have you ever been treated for or told you might have any of the following: (Please Circle)

Heart Disease	Diabetes	Liver Problems	Kidney Problems
Heart Murmur	Leukemia	Hepatitis	Ulcers
Artificial Heart Valve	Anemia	HIV Positive	Epilepsy
Rheumatic Fever	Asthma	AIDS	Venereal Disease
High Blood Pressure	Artificial Joint	Arthritis	Alcoholism
Cancer	Radiation Therapy	Chemotherapy	Stroke

8. Have you ever had any major surgery? _____ YES NO
   If so, please explain _____
9. Do you smoke, chew, use snuff, or any other form of tobacco? _____ YES NO
10. Have you had psychiatric treatment? _____ YES NO
11. Are you pregnant or suspect you may be? _____ YES NO
12. Do you use any birth control medications? _____ YES NO
13. Do you have any disease, conditions or problems not listed? _____ YES NO
    If so, please explain _____

I certify that the above information is complete and accurate.

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____ DATE _____