Medical History Form

Patient Information

First Name	Last Name	Date of Birth	Gender

Section One

Are you pregnant or trying to get pregnant? ☐ Yes ☐ No ☐ Not Applicable

Are you taking oral contraceptives? ☐ Yes ☐ No ☐ Not Applicable

Are you taking any medication? ☐ Yes ☐ No
If yes, please explain:

Do you use any tobacco? ☐ Yes ☐ No
If yes, please explain how often and how long have you been using them:

Do you use any controlled substances? ☐ Yes ☐ No
If yes, please explain what types of substances do you take, how often and how long have you been taking them:

Do you have any allergies? ☐ Yes ☐ No
If yes, please explain what you are allergic to, and what is the allergic reaction like:

Section Two

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

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disease
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting/Syncope
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stomach Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Venereal Diseases
- ☐ Jaundice

Patient Information

First Name	Last Name	Date of Birth	Gender

Section Two (Continued)

Have you had any serious illness not listed above? ☐ Yes ☐ No
If yes, please explain:

Additional Comments:

Section Three

Please list any past **surgeries**:

Month/Year	Reason	Hospital

Please list any **other hospitalization**:

Month/Year	Reason	Hospital

Section Four

All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health. It is my responsibility to inform the healthcare providers of any changes in their medical status.

Parent or Guardian Name (If Applicable)	Relationship to Patient (If Applicable)
Signature of Patient, Parent or Guardian	Date