MEDICAL HISTORY

- Name of family physician: _____
- Name of pharmacy: _____
- Are you being treated for any medical conditions at the present time or have you been treated within the last year? Yes ☐ No ☐ Not Sure ☐

  If so, why? _____

  _____
- When was your last medical check-up? _____
- Have there by any changes in your general health in the last year? Yes ☐ No ☐ Not Sure ☐

  If yes, please explain: _____

  _____
- Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Yes ☐ No ☐ Not Sure ☐

  If yes, please list: _____

  _____

  _____

  _____
- Are you allergic to:

  Medications: _____

  _____

  Latex/Rubber Products: _____

  Other: _____
- Have you ever had an uncommon or adverse reaction to any medicines or injections? Yes ☐ No ☐ Not Sure ☐

  If yes, please explain: _____

  _____
- Do you have or have you ever had asthma? Yes ☐ No ☐ Not Sure ☐

  Type of puffer: _____

  _____
- Do you have or have you ever had any heart or blood pressure problems? Yes ☐ No ☐ Not Sure ☐
- Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocardities), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Yes ☐ No ☐ Not Sure ☐
- Have you ever had hepatitis, jaundice or liver disease? Yes ☐ No ☐ Not Sure ☐

  Which type of hepatitis? _____
- Do you have a prosthetic or an artificial joint? Yes ☐ No ☐ Not Sure ☐

  If yes, please explain: _____

  _____
- Do you have a bleeding problem or a bleeding disorder? Yes ☐ No ☐ Not Sure ☐

  If yes, please explain: _____

  _____
- Have you been hospitalized for any illness or operation within the last 3 years? Yes ☐ No ☐ Not Sure ☐

  If yes, please explain: _____

  _____

  _____

  _____
- Have you ever had any of the following? Please check:

☐ AIDS
☐ Alzheimers
☐ Anemia
☐ Angina
☐ Arthritis
☐ Blood Transfusion
☐ Cancer
☐ Chest Pain
☐ Cold Sores
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Digestive Disorders / Acid Reflux
☐ Drug / Alcohol Dependency
☐ Emphysema
☐ Epilepsy or Seizures
☐ Fibromyalgia
☐ Head / Neck Injury
☐ Heart Attack
☐ Heart Murmur
☐ High / Low Blood Pressure
☐ HIV
☐ Hodgkins Disease
☐ Hypo / Hyperglycemia
☐ Kidney Disease
☐ Lung Disease
☐ Lupus
☐ Migraine
☐ Mitral Valve Prolapse
☐ Osteoporosis Medications (e.g. Fosamax, Actonel)
☐ Pacemaker
☐ Parkinsons Disease
☐ Radiation / Chemotherapy
☐ Rheumatic Fever
☐ Sexually Transmitted Infection
☐ Shortness of Breath
☐ Sleep Apnea
☐ Steroid Therapy
☐ Stomach Ulcers
☐ Stroke
☐ Thrush
☐ Thyroid Disorder
☐ TMJ Disorder
☐ Tuberculosis

- Are there any conditions or disease not listed above that you have or have had? Yes ☐ No ☐ Not Sure ☐

  If yes, please explain: _____

  _____

  _____

  _____
- Do you smoke or chew tobacco products? Yes ☐ No ☐ Not Sure ☐
- Are you pregnant? Yes ☐ No ☐ Not Sure ☐ N/A ☐

  _____

  _____

  _____

  _____

The information I have given above is true to the best of my knowledge.

PATIENT / GUARDIAN SIGNATURE _____ **DATE** _____

PRINTED NAME _____