

MEDICAL HISTORY

Patient: _____ Date of Birth: _____ Date: _____

Name of Physician: _____ Phone: _____

When was your last physical examination: _____

Circle a definite answer for each question:

YES NO Are you currently under the care of a physician?

If yes, describe your treatment _____

YES NO Have you ever had any surgery operation of any kind? If, yes describe: _____

YES NO Have you been advised by a physician of the need for any type of surgery or treatment? For what? _____

Do you have, have you had, or been treated for, any of the following?

YES NO Arthritis YES NO Panic attack, phobia, extreme nervousness

YES NO Rheumatic Fever YES NO Thyroid Condition

YES NO Heart Problems, Family History YES NO Venereal Disease, Herpes II

YES NO Acquired Immune Deficiency Syndrome(Aids)

YES NO High Blood Pressure YES NO Pacemaker

YES NO Low Blood Pressure YES NO Hip or Joint Replacement

YES NO Anemia, Sickle Cell Disease YES NO Seasonal Allergies

YES NO Epilepsy, Seizures YES NO Cancer

YES NO Fainting Spells YES NO Radiation or Chemical Therapy

YES NO Diabetes, Family History YES NO Ear Infections

YES NO Hepatitis YES NO Chronic Sinus

YES NO Ulcers YES NO Respiratory Problems, Asthma

YES NO Kidney Disorder YES NO Hemophilia, Bleeding or Blood Disorder

YES NO Tuberculosis (TB) YES NO Enzyme Deficiency

YES NO HIV YES NO Heart Murmur, Mitral Valve Prolapse

YES NO Hydrocephalus YES NO Metal Sensitivity

YES NO Anorexia, Bulimia YES NO Latex sensitivity

YES NO Chemical Dependency YES NO Chronic diarrhea

YES NO Have you been diagnosed with Sleep Apnea

Have you ever had an allergic reaction or been told not to take any medication? If, yes describe: _____

YES NO Are you currently taking any prescription drugs of any kind (example: Birth Control, Hormone, Diet)? If yes, what? _____

YES NO Are you currently taking any nonprescription drugs of any kind (Example: Aspirin, Cough Syrup, Nasal Spray, Recreational Drug Use, Sugar, Caffeine)? What? _____

YES NO Are you pregnant? Anticipated Delivery Date _____

YES NO Do you use any Tobacco Product? Daily Intake? _____

I certify the above to be true and correct to the best of my knowledge.

Signature _____ Date _____

Patient or Guardian