PATIENT MEDICAL HISTORY

Patients's Name:

Address:

City State Zip: **Email:**

Home Phone: **Cell Phone:** **Birth Date:** **Social Securty No.:**

Sex: **Marital Status:** **Emergency Contact Name and Number:**

If female, Please answer the following:

Y	N	
	■	Are you taking Birth Control pills?
	■	Are you pregnant? If Yes, # of weeks?
	■	Are you nursing?

Y	N	Conditions
	■	Artifical Joint Replacement
	■	Cancer W/Surgery
	■	Congenital Heart Defect
		Coumadin
		Heart Murmur
		Heart Surgery
		Mitral Valve Prolapse
		Pace Maker
		Premed
		Stent Replacement
		Abnormal Bleeding
		Alcohol Or Drug abuse
		Allergy To Local Anesthetic
		Angina Pectoris
		Asthma
		Blood Transfusion
		Canker Sores
		Chemotherapy
		Diabetes
		Difficulty Breathing
		Emotional Problems
		Do you smoke or use Tobacco
		Seizures
		Thyroid Problems

Y	N	Conditions
		Emphysema
		Epilepsy
		Fainting Spells
		Frequent Headaches
		Glaucoma
		HIV + Aids
		Hearing Aids
		Heart Attack
		Hemophilia
		Hepatitis
		Herpes
		High Blood Pressure
		High Cholesterol
		ITP- Platlet Count
		Immuno Suppressed
		Kidney Problems
		Leukemia
		Liver Problems
		Low Blood Pressure
		Migraines
		Psychiatric Problems
		Radiation Therapy
		Stroke
		Tuberculosis

Allergies	Y	N
Aspirin		
Codeine		
Dental Anesthetics		
Erythromycin		
Jewelry		
Latex		
Metals		
Penicillin		
Tetracycline		
Sulfa Drugs		

Other Allergies:

_____

_____

_____

_____

Other Conditions

_____

_____

_____

_____

_____

_____

_____

I certify that to the best of my knowledge the above information is complete and accurate.

Signature of Patient or Guardian

Date

PERSONAL MEDICATION RECORD

Name: Date of Birth:

Allergies:

Physician: Physician Phone #

Pharmacy: Pharmacy Phone #

	Name of Medication (Prescriptions, over-the-counter, eye drops, supplements, patches, herbals, inhalers, implanted pumps)	**Dose of Medicine** (Example: 20mg, one tablet)	**How Often Do You Take This Medication?** (Example: three times a day, at bedtime)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			