UPDATED MEDICAL HISTORY

Name _____ Date _____

First Middle Last Preferred Name

Physical Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Cell # _____ Home # _____ Work # _____ Emergency # _____

Email _____ Soc. Security # _____ Birthdate _____

Please circle:

Yes No Are you taking any medication? List:

Yes No Are you allergic to any medication? List:

Yes No Are you or have you taken medication for osteoporosis?

Yes No Do you have a history of a major illness?

Yes No Have you ever had surgery or been hospitalized?

Yes No Do you use any form of tobacco?

Yes No Do you have any allergies? (medications, materials, etc?)

Emergency contact + phone number:

_____

Pharmacy:

_____

primary care doctor:

_____

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

Yes / No Abnormal Bleeding	Yes / No Hemophilia	Yes / No Thyroid Problems
Yes / No Alcohol Abuse	Yes / No Heart Problems	Yes / No Tuberculosis
Yes / No Anemia	Yes / No Heart Surgery	Yes / No Ulcers
Yes / No Angina Pectoris	Yes / No Hepatitis A, B, or C (circle type)	
Yes / No Arthritis	Yes / No High Blood Pressure	
Yes / No Artificial Heart Valve	Yes / No Joint Replacement	
Yes / No Asthma	Yes / No Kidney Disease	
Yes / No Blood Transfusion	Yes / No Liver Disease	
Yes / No Cancer	Yes / No Low Blood Pressure	
Yes / No Chemotherapy	Yes / No Mitral Valve Prolapse	
Yes / No Colitis	Yes / No Pacemaker	
Yes / No Congenital Heart Defect	Yes / No Psychiatric Problems	
Yes / No Diabetes	Yes / No Radiation Therapy	
Yes / No Drug Abuse	Yes / No Rheumatic Fever	
Yes / No Emphysema	Yes / No Seizures	
Yes / No Epilepsy	Yes / No Sexually Transmitted Disease	
Yes / No Fainting Spells	Yes / No Shingles	
Yes / No Fever Blisters	Yes / No Sickle Cell Disease	
Yes / No Glaucoma	Yes / No Sinus Problems	
Yes / No HIV or AIDS	Yes / No Stroke	

For any YES marked above, please describe specific condition further: _____

Females only, please answer:

Yes / No Are you pregnant? If so, how many weeks? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

X _____ _____