

# PATIENT MEDICAL HISTORY

Y	N	<u>Conditions</u>	Y	N	<u>Conditions</u>	Y	N	<u>Conditions</u>																																							
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorders																																							
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells																																							
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems																																							
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse																																							
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer-Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse																																							
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/Anxious																																							
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer/Dementia																																							
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B,C	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;">Y</th> <th style="width: 5%;">N</th> <th style="width: 25%;"><u>Allergies</u></th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Aspirin</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Codeine</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Dental Anesthetics</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Erythromycin</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Jewelry</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Latex</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Metals</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Penicillin</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tetracycline</td></tr> <tr><td colspan="3">Other</td></tr> <tr><td colspan="3">_____</td></tr> <tr><td colspan="3">_____</td></tr> </tbody> </table>			Y	N	<u>Allergies</u>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	Jewelry	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	Metals	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline	Other			_____			_____		
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<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	HIV + Aids																																										
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters																																										
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Shingles																																										
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion																																										
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia																																										
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease																																										
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia																																										
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding																																										
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease																																										
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice																																										
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches																																										
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<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures																																										

<b>Sex</b>	<b>If female, please answer the following:</b>	<b>Please answer the following:</b>																								
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**Please list or attach medications:**

Y  N  **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below.....**

<b>Medical Doctor's Name</b>	<b>Phone Number</b>

<b>Patient's Signature</b>	<b>Patient Name</b>	<b>Date</b>