First Name:_____Last Name:_____MI:_____

Social Security # _____-_____-_____Birth Date____/____/_____ Home #(_____)_____

Work #(_____)_____ext_____ Cell #(_____)_____ E-mail _____

Address_____ Apt. #_____

City_____ State_____ Zip_____ Referred by _____

Employer_____Occupation_____ Male__ Female___Married___

**TELL US ABOUT YOUR MEDICAL HISTORY**

How would you describe your health? Please circle one Excellent Good Fair Poor

When did you have your last physical examination?_____

Are you currently being treated for any illness or medical condition? Yes_____No_____

If yes, please describe _____

_____

Who is treating you for this condition?_____

Have you ever had any kind of surgery? Yes____ No____ When did you have it?_____

What type of surgery did you have? _____

Have you ever had any trouble with prolonged bleeding after surgery? Yes_____ No_____

Do you have a pacemaker or any kind of artificial joint? Yes____ No____ Which? _____

Are you taking any medication or drugs at this time? Yes_____ No_____

What medications, drugs, or herbs are you taking?

_____

Why are you taking these medications? _____

_____

Ever had a reaction or complication to local anesthetic or drug(like novocaine or penicillin)? Yes____ No____

If yes, please explain _____

Please **circle Yes or No** to any present or past illness you now have or had in the past:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcoholism | Y | N | Diabetes (type___) | Y | N | Herpes | Y | N | Nervous or anxious | Y | N |
| Allergies | Y | N | Drug Dependency | Y | N | High Blood Pressure | Y | N | Neurologic Disorder | Y | N |
| Anemia | Y | N | Emphysema | Y | N | HIV/ AIDS | Y | N | Respiratory Disease | Y | N |
| Artifical Heart Valves | Y | N | Epilepsy | Y | N | Infectious Diseases | Y | N | Rheumatic Fever | Y | N |
| Artificial Joint | Y | N | Fainting or Dizzyness | Y | N | Kidney Disease | Y | N | Sickle Cell Disease | Y | N |
| Asthma | Y | N | Glaucoma | Y | N | Latex Sensitive | Y | N | Sinus Trouble | Y | N |
| Bleeding Disorder | Y | N | Head/Neck Injuries | Y | N | Liver Disease | Y | N | Take Cortisone | Y | N |
| Bruise Easily | Y | N | Heart Disease | Y | N | Lupus | Y | N | Stroke | Y | N |
| Cancer | Y | N | Heart Murmur | Y | N | Mental Illness | Y | N | Swollen Ankles | Y | N |
| Chemo or Radiation | Y | N | Heart Surgery(type__) | Y | N | Migraines | Y | N | Tuberculosis | Y | N |
| Chest Pain | Y | N | Hepatitis | Y | N | Mitral Valve Prolapse | Y | N | Ulcers | Y | N |

Are you allergic to Latex or any other substances or materials? Yes____ No____

If yes, please explain _____

If female, are you pregnant? Yes____ No____ What month? ____ Are you nursing? Yes____ No____

Is there any other information that should be known about your health? _____

_____

Signature of Patient (or Parent) _____ Date_____