

Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Physician's Phone: _____

Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you use tobacco in any form? Yes No

Have you had any metal rods, pins or implants placed? Yes No

Are you taking any medications? Yes No

Please list each one: _____

Have you ever had any surgical procedures? Yes No

Please list each one: _____

<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease																														
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems																														
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Stroke																														
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems																														
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis																														
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers																														
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"><input type="checkbox"/></td><td style="width: 5%;"><input type="checkbox"/></td><td style="width: 30%;">Allergies</td> </tr> <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> </table>			<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<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
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<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline																																				
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B																																	
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C																																	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure																																	
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement																																	
<input type="checkbox"/>	<input type="checkbox"/>	Collitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems																																	
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease																																	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure																																	
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse																																	
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker																																	
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems																																	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy																																	
<input type="checkbox"/>	<input type="checkbox"/>	Facial Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever																																	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Seizures																																	
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease																																	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Shingles																																	

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<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline

Nearest relative not living with you:

Name: _____ Relationship: _____

Address: _____ Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____