Doctor's Review

Medical History Update

Today's Date: mm|day|yr

Last Name | First Name | Initial | Birthdate mm|day|yr

So that we can provide you with the best possible care, please answer all questions.
Your answers are for our records only and will be considered confidential.

Primary Physician: Name | Address | Telephone

Secondary Physician: Name | Address | Telephone

Last Medical Examination: Day | Month | Year Reason:

In the last two years, have you been hospitalized or had a serious illness? Yes No

if yes, please explain:

Please list all prescription and non-prescription medications you are taking, including dosage:

medication [dosage]		medication [dosage]	
medication [dosage]		medication [dosage]	
medication [dosage]		medication [dosage]	

Have you ever been hospitalized or had a serious illness? Yes No

if yes, please explain:

Do you take Antacids? Yes No

Do you take Tagamet or Cimetidine? Yes No

Do you take herbal medications or dietary supplements? Yes No

Garlic Ginger Ma Huang Kava Ginko
Ginseng Ephedra St. Johns Wort Valerian other

Do you smoke or use tobacco products? Yes No

if yes, how frequent?

Do you have a pacemaker or prosthetic heart valve? Yes No

Women: Is there any chance you are pregnant? Yes No

Are you: Nursing Taking Birth Control

Are you allergic or sensitive to:

Dental Anesthetics (Shots)	General Anesthetics	Base Metals (costume Jewelry)
Penicillin	Other Antibiotics	Latex or Elastic
Aspirin	Ibuprofen (Motrin, Nuprin)	other
Codeine | Other Narcotics	Sedatives or Sleeping pills	other

Have you ever had:

Heart Trouble	Fainting or Dizziness	Swollen Ankles	Diabetes
Chest Pain	Stomach Trouble	Heart Attack	Ulcers
Heart Murmur	Shortness of Breath	Prolapsed Mitral Valve	Glaucoma
Low Blood Pressure	Hayfever	High Blood Pressure	Asthma
Frequent Headaches	Measles	Stroke	Night Sweats
Cancer	Goiter	Tumors	Thyroid Trouble
Radiation Therapy	Kidney | Bladder Trouble	Chemotherapy	Liver Dysfunction
Convulsions	Prosthetic Joint Replcmnt	Epilepsy	Lupus
Anemia	Tuberculosis	Yellow Jaundice	Venerial Disease
Hepatitis	Rheumatic Heart Disease	HIV | AIDS	Exzema | Hives
Bad Nose Bleeds	Psychological Problems	Prolonged Bleeding	Arthritis

Do you have a disease or condition not listed? Yes No

I have answered all questions to the best of my knowledge. Should the doctor deem necessary, you have my permission to request further information from appropriate providers or agencies and may communicate my release authorization.

Patient/Guardian Signature Month | Day | Year

Submit This Form

Reviewed mm | day | yr Doctor

WHERE ART MEETS SCIENCE

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