Doctor's Review

Medical History

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:

I am currently being treated for the following conditions:

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

Reviewed mm| day | yr Doctor

WHERE ART MEETS SCIENCE
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