Medical History Form

Title: ___________ Patient's Name ______________________________ Date of Birth ____________________

Emergency contact ______________________________ Tel. (   )____________________ Relation________________

Are you in good health? ☐ Yes ☐ No Are you under the care of a physician? Yes☐ No ☐

Have you had any illness, operations, or been hospitalized in the past years? ☐Yes ☐No **Pharmacy Phone number:** ____________________

Please list all medications you are taking (including natural, herbal or homeopathic products):______________________________

____

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Nerve Pills	☐	☐	Pain Killers (including aspirin)	☐	☐	Muscle Relaxers	☐	☐	Stimulants
☐	☐	Have you ever take diet pills	☐	☐	Tranquilizers	☐	☐	Insulin	☐	☐	Antidepressants
☐	☐	Blood Thinners (Coumadin, Aspirin, Advil)	☐	☐	Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax or Actonel)						

Are you allergic to or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Penicillin	☐	☐	Sulfa drugs/Sulfites	☐	☐	Local Anesthetic (numbing med)	☐	☐	Sodium Pentothal
☐	☐	Amoxicillin	☐	☐	Aspirin	☐	☐	Codeine or other narcotics	☐	☐	Latex
☐	☐	Valium or other tranquilizers	☐	☐	Eggs/Yolk	☐	☐	Bleach	☐	☐	Soy

Please list any other medication or antibiotic you are allergic to:

____

Please list any allergies other than drug allergies:

____

1-4 below for women only: (women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.)

(1) Is there a possibility of pregnancy? ☐ Yes ☐ No

(2) Expected Delivery Date: ____________________

(3) Are you nursing? ☐Yes ☐No

(4) Are you taking birth control pills? ☐ Yes ☐ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Rheumatic fever	☐	☐	Asthma	☐	☐	Bleeding tendency	☐	☐	Low Blood Sugar
☐	☐	Mitral Valve Prolapse	☐	☐	Hay Fever/Sinus Problems	☐	☐	Jaundice/Liver disease	☐	☐	Kidney trouble
☐	☐	Heart murmur	☐	☐	Snoring/Sleep apnea	☐	☐	Are you on dialysis	☐	☐	Hepatitis
☐	☐	High blood pressure	☐	☐	Respiratory problems	☐	☐	HIV/AIDS	☐	☐	Arthritis/Joint disease
☐	☐	Low blood pressure	☐	☐	Tuberculosis	☐	☐	Infectious mononucleosis	☐	☐	Stomach ulcers
☐	☐	Chest pain/angina	☐	☐	Emphysemia	☐	☐	Gallbladder trouble	☐	☐	Contagious disease
☐	☐	Heart attack (s)	☐	☐	Do you smoke?	☐	☐	Fainting spells	☐	☐	Delay in healing
☐	☐	Irregular heart beat	☐	☐	Do you use chewing tobacco	☐	☐	Convulsions/Epilepsy	☐	☐	Anemia
☐	☐	Cardia pacemaker	☐	☐	Blood transfusion	☐	☐	Stroke	☐	☐	Tumor or growth
☐	☐	Heart surgery	☐	☐	Blood disorder	☐	☐	Radiation/Chemotherapy	☐	☐	Thyroid trouble
☐	☐	Bronchitis/Chronic cough	☐	☐	Bruise easily	☐	☐	Are you on a diet?	☐	☐	Diabetes
☐	☐	Chronic fatigue/Night sweat	☐	☐	A history of drug abuse	☐	☐	History of alcohol abuse	☐	☐	Contact lenses
☐	☐	Mental health problems	☐	☐	Eye disease/Glaucoma	☐	☐	Sexually transmitted diseases	☐	☐	Abnormal bleeding
☐	☐	Immune system problems	☐	☐	Damaged heart valves	☐	☐	Malignant hyperthermia	☐	☐	Artificial joints
☐	☐	Are you immunosuppressed? (possibly from transplant surgery)	☐	☐	Problems with immune system? (possibly from med./surg.)						

Have you ever had any serious illness not listed above______________________________

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any error or omissions that I have made in the completion of this form.

Signature of patient: (Parent or Guardian if minor X ______________________________ Reviewed by: ____________________

FEES and PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. An **estimate** of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/ or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company**. You will be responsible for all collection costs, attorney's fees and court costs.

Signature of patient: (Parent of Guardian if minor) **X** ______________________________ Date: ____________________

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: (Parent or Guardian if minor) **X** ______________________________ Date: ____________________

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: (Parent or Guardian if minor) **X** ______________________________ Date: ____________________