Date_____

PATIENT HEALTH RECORD

Name_____ Spouse's Name_____

MEDICAL HEALTH

Name and address of physician:_____

Have you been under a physician's care during the past 2 years?_____ For:_____

Have you been treated in a hospital in the past 2 years?_____ For:_____

Have you ever had major surgery?_____

If female: Are you taking hormones or birth control?_____ Are you pregnant?_____

Are you nursing?_____

Have you ever had a blood test for Hepatitis?_____ Were you vaccinated?_____

Have you had cankers or cold sores on your lips, tongue, gums or body?_____

Are you now taking or have you taken any prescription drugs during the past year?_____

For:_____

Are you allergic to: Penicillin_____ Codeine_____ Local Anesthetics_____

Other:_____

Have you had or do you now have:

	yes	no		yes	no
Abnormal blood pressure	☐	☐	Hepatitis	☐	☐
Aids or HIV positive	☐	☐	Herpes	☐	☐
Allergies	☐	☐	Jaundice	☐	☐
Anemia	☐	☐	Kidney disease	☐	☐
Angina	☐	☐	Liver disease	☐	☐
Arthritis	☐	☐	Organ transplants	☐	☐
Artificial heart valves	☐	☐	Pacemaker	☐	☐
Artificial joints	☐	☐	Polio	☐	☐
Asthma	☐	☐	Prolonged bleeding	☐	☐
Cancer	☐	☐	Prolonged cough	☐	☐
Chemotherapy	☐	☐	Psychiatric treatment	☐	☐
Congenital heart lesions	☐	☐	Radiation therapy	☐	☐
Diabetes	☐	☐	Rheumatic fever	☐	☐
Drug dependency	☐	☐	Sickle cell anemia	☐	☐
Epilepsy	☐	☐	Stroke	☐	☐
Fainting	☐	☐	Thyroid disease	☐	☐
Glaucoma	☐	☐	Tuberculosis	☐	☐
Heart disease	☐	☐	Ulcers	☐	☐
Heart murmur	☐	☐	Venereal disease	☐	☐

Have you any disease, condition, or problem not previously listed?_____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY:
_____	_____	None ☐	_____	_____	_____
_____	_____	None ☐	_____	_____	_____
_____	_____	None ☐	_____	_____	_____
_____	_____	None ☐	_____	_____	_____
_____	_____	None ☐	_____	_____	_____
_____	_____	None ☐	_____	_____	_____