2020

Patient's Name: | **Date of Birth:** | **Sex:**

If female, please answer the following:

Y N
- ☐ ☐ Are you taking birth control pills?
- ☐ ☐ Are you pregnant? If yes, # of weeks: ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke/use tobacco? How much?_____

Height: _____

Weight: _____

Y	N	**Conditions**
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Heart Attack (year) _____
☐	☐	Heart Surgery (year) _____
☐	☐	Heart Valve Replacement

Y	N	**Conditions**
☐	☐	Hepatitis (type) _____
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Osteoporosis Medication (within last 5 years)
☐	☐	Pace Maker
☐	☐	Pain In Jaw
☐	☐	Pain in joints
☐	☐	Radiation
☐	☐	Seizures
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis

Y	N	**Conditions**
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	**Allergies**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetic
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	**Other:**

_____

_____

Medications/Supplements:

Y N ☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below:**

Signature: _____ **Date:** _____

(If under 18, Parent or Guardian signature required)

For Office Use Only:

BP: ☐

Heart Rate: ☐

Medical Alerts: