Name:

Medical Information

Primary Health Clinic: _____

Primary Physician: _____ Date of Last Exam: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, describe: _____

Have you ever had a surgical operation? ☐ Yes ☐ No

If yes, describe:

Have you ever had or currently have:

Y	N		Y	N	
☐	☐	Acid Reflux	☐	☐	Heart Murmur
☐	☐	ADD/ADHD	☐	☐	Heart Problems/Surgery
☐	☐	Allergies	☐	☐	Hemophilia
☐	☐	Anemia	☐	☐	Hepatitis
☐	☐	Angina Pectoris	☐	☐	High Blood Pressure
☐	☐	Anorexia or Bulimia	☐	☐	High Cholesterol
☐	☐	Arthritis	☐	☐	HIV-Aids
☐	☐	Asthma	☐	☐	Joint Replacement
☐	☐	Blood Transfusion	☐	☐	Kidney Disorder
☐	☐	Cancer	☐	☐	Liver Disease
☐	☐	Chemically Dependent	☐	☐	Pacemaker
☐	☐	Chronic Ear Infection	☐	☐	Pregnant Now
☐	☐	Chronic Sinus	☐	☐	Radiation or Chemo
☐	☐	Depression/Anxiety	☐	☐	Rheumatic Fever
☐	☐	PTSD	☐	☐	Sleep Apnea
☐	☐	Diabetes	☐	☐	Thyroid Condition
☐	☐	Emphysema	☐	☐	Tuberculosis
☐	☐	Epilepsy or Seizures	☐	☐	Ulcers
			☐	☐	Excessive Bleeding

Do you need to take a Premed? ☐ Yes ☐ No If yes, did you take it today? ☐ Yes ☐ No

Any other medical condition not listed:

Are you allergic to any medication? ☐ Yes ☐ No

If yes, describe

_____

Are you currently taking any non-prescription medication (e.g. aspirin, Tylenol, Vitamins)? ☐ Yes ☐ No

If yes, describe

Are you currently taking ANY prescription medication? ☐ Yes ☐ No Dry mouth? Yes ☐ No ☐

If yes, describe

Do you use any tobacco products? ☐ Yes ☐ No Daily Intake:

I hereby authorized that information on the medical history form is accurate and true.

Patient/Guardian Signature Date: