Patient Medical History Form

Patient Name: _____ Date: _____/_____/_____

D.O.B: ____/____/_____ Reason For Visit: _____ Weight: _____

1. Allergic to any medication? Y/N List: _____

2. Taking any medication now? Y/N List: _____

3. Any previous surgery? Y/N List: _____

4. Date of last tetanus shot: _____

Please check all that apply:

_____ High Blood Pressure _____ Diabetes _____ Asthma _____ Depression

_____ Anxiety _____ Heart Attack _____ Acid Reflux _____ Hypo/Hyperthyroidism

_____ Other: _____

_____ Smoke _____ Drink Alcohol

FEMALE PATIENTS ONLY

DATE OF LAST MENSTRUAL CYCLE: _____

ARE YOU TAKING BIRTH CONTROL? (circle one): YES OR NO

COULD YOU BE, OR ARE YOU PREGNANT? (circle one): YES OR NO

Please tell us how you found out about our clinic:

Have you or a member of your family been a patient at this clinic before? Yes or No

____ Received advertisement in mail ____ Insurance Company ____ Used Clinic Before

____ Referred by Family or Friend ____ Brochure/Magnet ____ Saw Sign

____ Referred by Doctor: _____

____ Referred by Hotel: _____

____ Other: _____

_____ Date: _____/_____/ _____

Signature of patient or parent/guardian if minor