Medical Information

Date:_____

Name:	Birth Date:	Weight/Height:
Emergency Contact:	Relationship:	Phone:
Primary Physician:	Last Visit Date:	Phone:
Specialist Physician(s):	Last Visit Date(s):	Phone(s):

1.) Do you suffer from or have you been treated for any of the following? (check any that are applicable.)

Cardiovascular	√	**Nervous System**	√	**Respiratory**	√	**Endocrine**	√
CAD (angina, heart attack)		Seizures/Epilepsy		COPD		Thyroid Disorders	
Heart Failure (weak heart)		Depression or Panic Attacks		Emphysema		Diabetes Mellitus	
High Blood Pressure		Psychosis or Mania		Chronic Bronchitis		Immune Disorder	
Low Blood Pressure		Multiple Sclerosis		Asthma		Pregnant (Due Date:)	
Arrhythmias (irregular beat)		Headaches/Migraine		Sinus / Hay Fever		Breast-Feeding	
Congenital heart defect		Substance Abuse		Obstructive Sleep			
Valve Disease or Murmur		Alzheimer's/other Dementia				**Excretory**	
Artificial Heart Valve		Physical/Mental Impairment		**Miscellaneous**		Liver Disorder(noninfectious)	
Endocarditis (Heart Infection)		**Infections**		Cancer		Kidney Disorder	
Stroke or TIA		Hepatitis		Joint Replacement		Bladder Disorder	
Bleeding Problems		HIV / AIDS		Organ Transplant		Ulcers or GERD	
Blood Disorders		Tuberculosis		Glaucoma		Intestinal Problems	

2.) Please list any medical problems you have that are not listed in this table:

3.) Have you ever received a local anesthetic? Y / N A general anesthetic? Y / N Any problems? Y / N

4.) Please list any allergies to medication, foods or any other substances:

5.) Please list all medications you are taking, including non-prescription products:

Baseline Vital Signs: BP_____ HR_____

For Office Use Only

Summary Notes Following Interview:

Date Updated:	Initials: