MEDICAL INFORMATION FORM

Dear Patient,

Please answer the following medical questions. ***Please be reassured that patient privacy is a top priority!*** **(Please ask a receptionist to see our HIPPA privacy policy, if you wish.)**

1) Name: ____________________ Today's Date: _______________
2) Reason for your visit (Enter Details)?

3) Have you ever had any of these medical problems (check all that apply) or check "No History of Significant Medical Problems"?

NO HISTORY OF SIGNIFICANT MEDICAL PROBLEMS.

☐ Angina Pain	☐ Heart Murmur	☐ Productive Cough
☐ Asthma	☐ Hepatitis	☐ Reflux (GERD)
☐ Bleeding Disorder	☐ Hypertension (High Blood Pressure)	☐ Renal Failure
☐ CHF (Congestive Heart Failure)	☐ Obesity	☐ Rheumatic Failure
☐ Complication of Anesthesia	☐ Orthopnea (Difficulty Breathing, Lying Down)	☐ Seizure
☐ CVA (Cerebral Vascular Accident)	☐ Oxygen Dependent	☐ Sleep Apnea
☐ Diabetes	☐ Pedal Edema (Swelling of Ankles/Feet)	☐ EPILEPSY
☐ Dysrhythmia (Irregular Heartbeat)	☐ Pregnancy Complications	☐ Thyroid Condition

Significant Problem(s) Not Listed Above: ____.

Currently Pregnant Yes No

Planning Pregnancy Yes No

4) Medications (please check, if applicable): ☐ **I CURRENTLY TAKE NO MEDICATIONS**
or Please check if you currently take the following... Blood Thinning Medications:

☐ Aggrenox	☐ Pradaxa
☐ Coumadin	☐ Aspirin
☐ Lovenox	☐ Heparin
☐ Plavix	☐ Xarelto

Please check if you currently take any of the following:

☐ Ibuprofen / Aleve or Other NSAIDS	☐ Vitamins

Enter Other Medications Being Taken:

→

5) Do you have allergic reactions to any of the following (please check all that apply) or please check "No Known Drug Allergies"?

☐ **NO KNOWN DRUG ALLERGIES.**

☐ Ace Inhibitors	☐ NSAIDS (Ibuprofen/Aleve)
☐ Aspirin	☐ Penicillin's
☐ Erythromycins	☐ Sulfa Drugs
☐ IVP Dye, Iodine Containing Latex	☐ Tetracycline's

Allergic Reactions(s) Not Listed Above: ______________________________.

6) Social History:

Do you, (please check)?

☐ Never Smoked	☐ Former Smoker
☐ Current Occasional Smoker	☐ Current Every Day Smoker
☐ Alcohol Social Drinker ( ) or Everyday ( )	☐ Never Drink Alcohol

7) Family History:

Please **CHECK MARK** the following major medical conditions in your family.

Do not include adopted family members.

☐ NO SIGNIFICANT FAMILY MEDICAL PROBLEMS

Relation:	MOTHER	FATHER	SISTER	BROTHER	GRANDMOTHER	GRANDFATHER
ARTHRITIS	☐	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐	☐
BLEEDING	☐	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐	☐
CORONARY HEART DISEASE	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐
DRUG DEPENDENCE	☐	☐	☐	☐	☐	☐
EPILEPSY	☐	☐	☐	☐	☐	☐
GLAUCOMA	☐	☐	☐	☐	☐	☐
HEART ATTACK	☐	☐	☐	☐	☐	☐
HIGH CHOLESTEROL	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐
MIGRAINES	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐
THYROID CONDITION	☐	☐	☐	☐	☐	☐