PATIENT'S NAME

_____

Last First Middle Initial

_____

Date of Birth

Physician's Name _____

Physician's Address _____

Are you currently under a physician's care? Yes No

If yes, since when _____ Why _____

When was your last complete physical exam? _____

Please circle appropriate answer:

1. Are you currently taking any medication? Yes No
   If yes, please list:_____
   _____
   _____
2. Do you routinely take health-related substances? (Vitamins etc.) Yes No
3. Are you allergic to any medications or substances? Yes No
   If yes, what _____
4. Do you have any other allergies? _____ Yes No
5. Do you have any problems with __penicillin, __antibiotics, __anesthetics or other medications? Yes No
   If yes, what _____
6. Are you sensitive to any __metals or __latex? Yes No
7. Are you pregnant, or suspect that you may be? Yes No
8. Do you use any birth control medications? Yes No
9. Have you ever been treated for, or been told that you might have, heart disease? Yes No
   If yes, please explain _____
10. Do you have a __pacemaker or __artificial heart valve implant? Yes No
11. Have you ever had rheumatic fever? Yes No
12. Are you aware of any heart murmurs? Yes No
13. Do you have __high or __low blood pressure? Yes No
14. Have you ever had a serious illness or major surgery? Yes No
    If yes, please explain_____
15. Have you ever had __radiation treatment or __chemotherapy for a __tumor, __growth or __other condition? Yes No
16. Do you have inflammatory diseases such as __arthritis or __rheumatism? Yes No
17. Do you have an artificial joint prosthesis? Yes No
    If yes, please explain_____
18. Do you have any blood disorders such as __anemia, __leukemia, etc.? Yes No
19. Have you ever bled excessively after being cut or injured? Yes No
20. Do you have any __stomach problems, __kidney problems, or __liver problems? Yes No

21. Are you diabetic?	Yes	No
22. Do you have asthma?	Yes	No
23. Do you have __epilepsy or __seizure disorders?	Yes	No
24. Have you had or do you test positive for hepatitis?	Yes	No
25. Do you currently have, or have you ever had, tuberculosis?	Yes	No
26. Do you or have you had venereal disease?	Yes	No
27. Have you ever had a **positive** test for HIV?	Yes	No
28. Do you have AIDS?	Yes	No
29. Do you __smoke, __chew, __use snuff, __or any other forms of tobacco?	Yes	No
30. Do you habitually use controlled substances?	Yes	No
31. Have you had psychiatric treatment?	Yes	No

Do you have any disease, condition, or problem not listed? Yes No

If yes, please explain._____

Is there anything else we should know about your health that we have not covered in this form? Yes No

If yes, please explain._____

_____

Would you like to speak to the doctor privately about any problems? Yes No

I certify that the above information is complete and accurate.

Patient's signature _____ Date_____

Doctor's signature _____ Date _____