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	☐ Thyroid Condition

Significant Problem(s) Not Listed Above: _____.

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	☐	☐	☐	☐	☐	☐