

Medical Information Form

Patient information			
First name:	Last name:		
Date of birth:	Gender:		
Section one			
Are you pregnant or trying to get pregnant?	Yes	No	Not applicable
Are you taking oral contraceptives?	Yes	No	Not applicable
Are you taking any medication?	Yes	No	Not applicable
If yes, please explain:			
Do you use any tobacco?	Yes	No	Not applicable
If yes, please explain how often and how long have been using them:			
Do you use any controlled substances?	Yes	No	Not applicable
If yes, please explain what types of substances do you take, how often, and how long have you been taking them:			
Do you have any allergies?	Yes	No	Not applicable
If yes, please explain what you are allergic to, and what is the allergic reaction like:			

Section two**Do you have, or have you had, any of the following?**

AIDS/HIV positive	Fainting/syncope	Mitral valve prolapse
Alzheimer's disease	Frequent cough	Osteoporosis
Anemia	Frequent diarrhea	Pain in jaw points
Angina	Frequent headaches	Parathyroid disease
Arthritis gout	Genital herpes	Psychiatric care
Artificial heart valve	Glaucoma	Radiation treatment
Artificial joint	Hay fever	Renal dialysis
Asthma	Heart attack/failure	Rheumatic fever
Blood disease	Heart murmur	Rheumatism
Blood transfusion	Heart pacemaker	Scarlet fever
Breathing problem	Heart trouble/disease	Shingles
Bruise easily	Hemophilia	Sickle cell disease
Cancer	Hepatitis A	Sinus trouble
Chemotherapy	Hepatitis B or C	Stomach disease
Chest pain	Herpes	Sinus trouble
Cold sores/fever blisters	High blood pressure	Stomach disease
Congenital heart disease	High cholesterol	Stroke
Convulsions	Hives or rash	Swelling of limbs
Cortisone medicine	Hypoglycemia	Thyroid disease
Diabetes	Irregular heartbeat	Tonsillitis
Drug addiction	Kidney problems	Tuberculosis
Easily winded	Leukemia	Tumors or growths
Emphysema	Liver disease	Venereal diseases
Excessive bleeding	Low blood pressure	Jaundice
Excessive thirst	Lung disease	

Have you had any serious illness not listed above?

Yes

No

If yes, please explain:

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Additional comments:

Section three

Please list any past surgeries:

Month/Year	Reason	Hospital

Please list any other hospitalization:

Month/Year	Reason	Hospital

Insurance information (if applicable):

Insurance carrier:	Insurance plan:	Contact number:
Policy number:	Group number:	Social security number:

All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health. It is my responsibility to inform the healthcare providers of any changes in their medical status.

Parent or guardian name:

Relationship to patient:

Signature of patient, parent or guardian:

Date: