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:

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:		