

Medical Information Form

Patient Information			
First Name	Last Name	Date of Birth	Gender
Section One			
Are you pregnant or trying to get pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable			
Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable			
Are you taking any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:			
Do you use any tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain how often and how long have you been using them:			
Do you use any controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No 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? <input type="checkbox"/> Yes <input type="checkbox"/> No 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?			
<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Anemia	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> Angina	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis Gout	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Shingles
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting/Syncope	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Stomach Disease
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Mitral valve Prolapse	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Venereal Diseases
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Jaundice

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Section Two (Continued)

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 (If Applicable)	Relationship to Patient (If Applicable)
Signature of Patient, Parent or Guardian	Date