



WFDCDTINC179

PATIENT MEDICAL HISTORY

Patient Information

Full Name: _____

Date of Birth: _____

Social Security #: _____

Sex: _____

Medical History

Are you currently under a physician's care? Yes No If yes, name of physician(s) and condition(s): _____

Prior **hospitalizations** and dates: _____

Prior **medical problems**: _____

Prior **surgeries** and dates: _____

Medications and doses: _____

Drug or environmental **allergies**: _____

Do you currently **smoke**? Yes No If yes, How much? _____

Women only: Are you pregnant? Yes No Are you taking birth control pills? Yes No

Are you nursing? Yes No Are you on hormone therapy? Yes No

Medical Alerts:

- Allergic to 'Novocaine'
- Allergic to Latex Rubber
- Pre-Medication required
- Pacemaker
- Heart Problems
- Mitral Valve Prolapse
- Prior Hepatitis
- HIV Positive
- Other: _____

Current or Previous Conditions

 Select any of the following if you presently have, or have had in the past:

Cosmetic	<input type="checkbox"/> Surgery	<input type="checkbox"/> Laser treatment	<input type="checkbox"/> Injections	
Heart	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Congenital Heart Problem
	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Artificial Heart Valve	
Bleeding & Clotting	<input type="checkbox"/> Excessive Bleeding when Cut	<input type="checkbox"/> Excessive Bruising	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Blood Disease
	<input type="checkbox"/> Deep Vein Clot	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hemophilia	
Diabetes/Thyroid	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Excessive Thirst
Infection	<input type="checkbox"/> Hepatitis A or B	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Herpes	<input type="checkbox"/> Cold Sores/Fever Blisters
Psychiatric	<input type="checkbox"/> Obsessive/Compulsive Disorder	<input type="checkbox"/> Depression	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Body Dysmorphic Disorder
	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Suicidalities	<input type="checkbox"/> Chemical Dependency	
Eye & Nose	<input type="checkbox"/> Dry Eye	<input type="checkbox"/> Eye Allergies	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Glaucoma
	<input type="checkbox"/> Nasal Blockage	<input type="checkbox"/> Nasal Fracture	<input type="checkbox"/> Sinus Allergies	<input type="checkbox"/> Sinusitis
Cancer	<input type="checkbox"/> Skin	<input type="checkbox"/> Breast	<input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Previous Radiation	<input type="checkbox"/> Previous Chemotherapy		
Lung	<input type="checkbox"/> Pulmonary Embolus	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Cough	<input type="checkbox"/> Asthma
Orthopedic	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Arthritic Joints	<input type="checkbox"/> Artificial Joint Placement	
Kidney/Liver	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Stones	<input type="checkbox"/> Jaundice
Neurologic	<input type="checkbox"/> Seizure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Migraines	<input type="checkbox"/> Epilepsy or Seizures
Other	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Fainting or Dizziness	<input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Unusual Reactions to Anesthesia		<input type="checkbox"/> Swelling of Feet/Ankles	<input type="checkbox"/> Other: _____

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my doctor, or any other member of the staff, responsible for any errors or omissions that I may have made in completion of this form.

Patient Signature: _____

Date: _____

Nurse's Signature: _____

Date: _____

(Upon review with patient)