MEDICAL HISTORY QUESTIONNAIRE

This is your medical history form to be completed prior to your first appointment. All information will be kept confidential.

Do you have or ever had the following: (check only ones that apply)

____ JOINT REPLACEMENT
____ HEART MURMUR
____ HEART SURGERY
____ HIGH/LOW BLOOD PRESSURE
____ HIGH CHOLESTEROL
____ CURRENTLY PREGNANT
____ DIABETES
____ RHEUMATIC FEVER

____ ANEMIA
____ CANCER
____ ABNORMAL BLEEDING
____ EPILESPY/SEIZURES
____ HEPATITIS A
____ HEPATITIS B
____ HEPATITIS C
____ AIDS/HIV INFECTION

OTHER:(please list) ____

ALLERGIC TO:

___NONE ___PENICILLIN___SULFA___LATEX___OTHER____

MEDICATIONS YOU ARE CURRENTLY TAKING:

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

OFFICE USE ONLY

SERVICES RENDERED:

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