Medical Information Form

Patient Name:_________________________________ D.O.B.:_____________________________

Patient Medical Information:

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS FOR TREATMENT AND YOU HEALTH

Age:_________ Height:____________ Weight:______________ Shoe Size:___________________

Primary Care Physician:___________________________ Phone Number:____________________

What Is The Reason For Your Visit Today?____

PLEASE MARK ANY OF WHICH APPLY TO YOU:

__ Diabetes __ Seizure Disorders __ Arthritis

__ Heart Trouble __ Bleeding Disorders __ Asthma

__ Circulatory Problems __ Hypertension(High BP) __ Epilepsy

__ Kidney Trouble __ Hypotension (Low BP) __ Hepatitis

__ Rheumatic Fever __ Nervous Condition __ Stroke

__ Stomach Ulcers __ Sickle Cell Anemia __ Heart Attack

__ Skin Problems __ Liver Disease __ Cholesterol Problems

__ Tuberculosis __ Epilepsy / Seizures __ Anemia

__Glaucoma __ Back Problems __ Eating Disorders

__Joint Replacements __ Scarlet Fever __ Pacemaker

__Chest Pain __ Swelling of Feet __ Blood Disease

__Other:____

ALLERGIES:(MARK WHAT APPLIES TO YOU)

__ Foods __ Sulphites __ Iodine

__ Aspirin __ Sulphur __ Tape

__ Codeine __ Local Anesthesia __ Penicillin

__ Novocaine __ Dyes

__Other:____

Past Surgical History:____

____

Present Medications:____

____

Family History: Diabetes, Circulatory, Hypertension, Bleeding Disorders, Arthritis, Problems with Anesthesia, Other:____

Social History:

Tobacco Use: Y/N (Pks/Day)________ Coffee: (Cups)_______ Alcohol:___________

Do You Take Aspirin Daily? Y/N Do You Faint Easily: Y/N