NAME:_____ **DATE:**_____
(Please Print)

MEDICAL HISTORY

Medical Doctor's Name_____

Medical Doctor's Phone #_____ Last Visit _____

Are you in good health with no known medical problems? Yes / No

Have you had: **Date:**

Heart valve replacement	Yes / No	_____
Mitral valve prolapsed with regurgitation	Yes / No	_____
Recent by-pass surgery	Yes / No	_____
Joint replacement	Yes / No	_____
Immune system disorders	Yes / No	_____
Current chemotherapy/radiation treatment	Yes / No	_____

Have you ever had any of the following diseases or medical problems?

Y / N Anemia / Radiation Treatment	Y / N Delayed healing/clotting
Y / N Artificial Bones / Joints	Y / N Heart Surgery / Pacemaker
Y / N Artificial Valves	Y / N Hemophilia / Abnormal Bleeding
Y / N Asthma / Arthritis	Y / N Hepatitis / Liver Disease
Y / N Blood Transfusion	Y / N High / Low Blood Pressure
Y /N Cancer / Chemotherapy	Y / N HIV+ / AIDS
Y / N Congenital Heart Defect	Y / N Hospitalized for Any Reason
Y / N Diabetes / Tuberculosis (TB)	Y / N Kidney Problems
Y / N Difficulty Breathing	Y / N Mitral Valve Prolapse
Y / N Drug / Alcohol Abuse	Y / N Psychiatric Problems
Y / N Emphysema / Glaucoma	Y / N Rheumatic / Scarlet Fever
Y / N Epilepsy/Seizures/Fainting Spells	Y / N Severe / Frequent Headaches
Y / N Fever Blisters / Herpes	Y / N Shingles
Y / N Heart Attack / Stroke	Y / N Sinus Problems
Y / N Heart Murmur	Y / N Ulcers / Colitis / Stomach problems
Y / N Immune System Problems	Y / N Venereal Disease
	Y / N Thyroid Problems

Please list any other serious medical conditions(s) that you have ever had:

Are you allergic to any of the following?

Y / N Aspirin	Y / N Erythromycin	Y / N Tetracycline
Y / N Codeine	Y / N Latex	Y / N Other
Y / N Dental Anesthetics	Y / N Penicillin	

Please list any other drugs that you are allergic to:

Do you smoke or use tobacco in any other form? Yes/No

Are you taking any prescription/over the counter drugs? Yes/ No

List each one:_____

_____

_____

_____

_____

_____

_____

For Women:

Are you taking birth control pills?	Yes / No	
Are you pregnant?	Yes / No	Week #_____
Are you nursing?	Yes / No	

I understand that the information that I have given today Is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it Is my responsibility to inform this office of any changes in my medical status.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. A minimum charge will be made for failed or cancelled appointments Without prior notification of 24 hours.

Signature (Parent or Guardian if Patient is a minor) **Date**

Notice of Privacy Practices Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.