Medical Information Form

PATIENT INFORMATION

[ClientInfo]: _____

SECTION ONE

Are you pregnant or trying to get pregnant?

◯ Yes ◯ No ◯ Not applicable

Are you taking oral contraceptives?

◯ Yes ◯ No ◯ Not applicable

Are you taking any medication?

◯ Yes ◯ No ◯ Not applicable

If yes, please explain:

Do you use any tobacco?

◯ Yes ◯ No

If yes, please explain how often and how long have been using them:

Do you use any controlled substances?

◯ Yes ◯ No ◯ Not applicable

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?

◯ Yes ◯ No ◯ Not applicable

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?

Medical conditions

- [ ] AIDS/HIV positive
- [ ] Alzheimer's disease
- [ ] Anemia
- [ ] Angina
- [ ] Arthritis gout
- [ ] Artificial heart valve
- [ ] Artificial joint
- [ ] Asthma
- [ ] Blood disease
- [ ] Blood transfusion
- [ ] Breathing problem
- [ ] Bruise easily
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Chest pain
- [ ] Cold sores/fever blisters
- [ ] Congenital heart disease
- [ ] Convulsions
- [ ] Cortisone medicine
- [ ] Diabetes
- [ ] Drug addiction
- [ ] Easily winded
- [ ] Emphysema
- [ ] Excessive bleeding
- [ ] Excessive thirst
- [ ] Fainting/syncope
- [ ] Frequent cough
- [ ] Frequent diarrhea
- [ ] Frequent headaches
- [ ] Genital herpes
- [ ] Glaucoma
- [ ] Hay fever
- [ ] Heart attack/failure
- [ ] Heart murmur
- [ ] Heart pacemaker
- [ ] Heart trouble/disease
- [ ] Hemophilia
- [ ] Hepatitis A
- [ ] Hepatitis B or C
- [ ] Herpes
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] Hives or rash
- [ ] Hypoglycemia
- [ ] Irregular heartbeat
- [ ] Kidney problems
- [ ] Leukemia
- [ ] Liver disease
- [ ] Low blood pressure
- [ ] Lung disease
- [ ] Mitral valve prolapse
- [ ] Osteoporosis
- [ ] Pain in jaw points
- [ ] Parathyroid disease
- [ ] Psychiatric care
- [ ] Radiation treatment
- [ ] Renal dialysis
- [ ] Rheumatic fever
- [ ] Rheumatism
- [ ] Scarlet fever
- [ ] Shingles
- [ ] Sickle cell disease
- [ ] Sinus trouble
- [ ] Stomach disease
- [ ] Stroke
- [ ] Swelling of limbs
- [ ] Thyroid disease
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Tumors or growths
- [ ] Venereal diseases
- [ ] Jaundice

Have you had any serious illness not listed above?

◯ Yes ◯ No

If yes, please explain:

Additional comments:

SECTION THREE

Please list any past surgeries:

1. Month/Year: _____

Reason:

Hospital: _____ 2. Month/Year: _____

Reason:

Hospital: _____ 3. Month/Year: _____

Reason:

Hospital: _____

Please list any other hospitalization:

1. Month/Year: _____

Reason:

Hospital: _____ 2. Month/Year: _____

Reason:

Hospital: _____ 3. Month/Year: _____

Reason:

Hospital: _____ 4. Month/Year: _____

Reason:

Hospital: _____

INSURANCE INFORMATION (IF APPLICABLE)

Insurance carrier: _____ Insurance plan: _____

Contact number: _____ Policy number: _____

Group number: _____ Social security number: _____

Parent or guardian name: _____ Relationship to patient: _____

Signature of patient, parent or guardian:

Date: _____ dd / mm / yyyy