MEDICAL HISTORY UPDATE

Today's date:____

First name :______________________________Last name:_______________________________________

Date of birth:____

Email address:____

Please update your address and telephone number with our admin team.

Are you presently under a physician's care? Monthly? Every 3months?... YES/NO

If YES, what condition? ____

Have you ever been hospitalized overnight? YES/NO

If YES, what for? ____

Are you currently taking any medications, including aspirin? Please provide admin with a photocopy of your current medications: YES/NO

If YES, please list ____

Do you have any allergies? Latex? YES/NO

If YES, what are you allergic to? ____

Do you have any artificial body parts? Joints? Pacemakers? YES/NO

If YES, please list ____

Do you have any infections we should be aware of? YES/NO

If YES, please explain ____

Do you have or have you had any of the following?

Hepatitis, jaundice, liver disease	YES/NO	Thyroid problems	YES/NO
Rheumatic fever	YES/NO	Cancer or radiation therapy	YES/NO
Heart Murmur	YES/NO	Taking bisphosphonates	YES/NO
Heart Trouble	YES/NO	Glaucoma	YES/NO
High or low blood pressure	YES/NO	Prolonged bleeding from a minor cut	YES/NO
Liver problems	YES/NO	Tuberculosis	YES/NO
Asthma or sinus problems	YES/NO	Do you have sleep apnea?	YES/NO
Diabetes	YES/NO	Are you a nervous patient?	YES/NO
Arthritis or rheumatism	YES/NO	Any other serious illness?	YES/NO
Do you smoke?	YES/NO	Epilepsy or nervous problems	YES/NO
WOMEN:			
Are you pregnant:	YES/NO		

Patient signature:____

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