MEDICAL HISTORY UPDATE

Patient name	Date	Date of birth	
Physician's name	Physician's phone:	Physician's phone:	
List medications presently taken and for what conditions.			
Are you now or have you been treated for osteoporosis?			
List any medications taken in the last two years.			
List herbal supplements.			
Do you smoke or chew tobacco? Have you taken diet medication (Fen-Phen)?	Have you been under a	physician's care during the past two years?	
Have you ever had any major surgery?	If female: Are you taki	ng hormones or birth control medication?	
Have you been treated in a hospital in the past two years?	Are you (or could be) pr	Are you (or could be) pregnant or nursing?	
[] [] Artificial heart valves [] [] Artificial joints (hips, knees, etc.) [] [] Cancer [] [] Cardiac pacemaker [] [] Chemotherapy/radiation [] [] Congenital heart lesions [] [] Diabetes [] [] Heart disease [] [] Heart murmur [] [] Heart surgery [] [] Hepatitis [] [] Herpes labialis (cold sores) [] [] Mitral valve prolapse [] [] Rheumatic fever [] [] Fainting, of the content of t	ves sthetics ependency/addiction hay fever heumatism disorder ssure (low) ssure (high) able/bleed easily bers (Recurrent Apthous Ulce endency/addiction ma/COPD seizures se convulsions neadaches	Yes No [] [] Other medications (Please List) Yes No [] [] Hemophilia/bleeding disorder [] [] Irregular heartbeat [] [] Jaundice [] [] Kidney disease [] [] Leukemia [] [] Liver disease [] [] Organ transplant [] [] Polio [] [] Polio [] [] Prolonged cough [] [] Psychiatric treatment [] [] Respiratory problems [] [] Respiratory problems [] [] Sickle cell anemia [] [] Sexually transmitted diseases [] [] Sinus trouble [] [] Stroke [] [] Thyroid disease [] [] Tuberculosis [] [] Ulcers	
Do you have any disease, condition, or problem not previously list			
Signature			
Office Use Only			
Date: Date: Date:	Date:	_ Date: Date:	
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