

**Medical Information**

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

What is the reason or nature of the concern that brings you here today?

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How long has the condition existed?

What have you done to treat the condition?

Are you having any pain? **Yes or No**

**If yes:** please rate pain on a scale of 1-10 (1 being no pain and 10 being the worst pain that you ever felt) 1 2 3 4 5 6 7 8 9 10 – **circle one**

Describe the location of your pain.

When you are having pain, do any activities or movements make your pain better or worse? (i.e. walking, rest, elevation)

What is your present height \_\_\_\_\_ and weight \_\_\_\_\_ ?

Are you presently being treated for any medical conditions? Please list below (i.e. Diabetes, Heart conditions, kidney, Hepatitis B or C, HIV, Tuberculosis, Vascular Disease, Raynaud's disease or phenomenon, Gout, etc.)

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Do you have any history of sexually transmitted diseases?

Have you been treated for any medical conditions in the past? Please list below.

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Please list any medication that you are presently taking (including antibiotics, pain medications, allergy medications, aspirin or Coumadin, Steroids, Insulin, Heart, etc.).

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Name \_\_\_\_\_ Date \_\_\_\_\_

### Medical Information Continued

Are you allergic to any medications? If so, please circle below: describe the type of reaction that you have experienced next to allergy (i.e. rash, hives, difficulty breathing).

- Penicillin
- Iodine/Shellfish
- Sulfa
- Adhesives/Tape
- Codeine
- Aspirin/NSAIDS
- Anesthetics/"Novocaine"
- OTHER – please list

When was your last TETANUS shot? Less than 5 years/Greater than 5 years/Can't Recall (Circle One)

Have you received a Flu shot for this year?

Please list any childhood illnesses you may have had (i.e. Measles, Mumps, Chicken Pox, Polio, Scarlet Fever, etc.)

Do you require antibiotics before regular Dental visits? Do you have Mitral Valve Prolapse?

Please list any surgeries that you have had along with the year (to the best of your recollection).

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Do you smoke (presently or in the past)? How many packs per day? How many years?

Do you consume alcoholic beverages (occasionally or greater than 2 drinks per day)?

Any history of I.V. drug use or other narcotic use?

**\*All information is kept confidential.**

Name \_\_\_\_\_ Date \_\_\_\_\_

**Medical Information Continued**

**Please Circle Any Conditions as They Apply to You:**

Headaches Migraine Blurred or Double Vision Vertigo Fainting Bloody Noses  
Cataracts Glaucoma Sore Throat Nasal Polyps Sinusitis Bleeding Gums Tinnitus

Asthma Bronchitis Tuberculosis Asbestosis Shortness of Breath Mitral Valve  
Prolapse Pacemaker High Cholesterol Sickle Cell Anemia or Trait Anemia  
Bleeding Disorder Murmur Arrhythmia High Blood Pressure Circulatory Disorders  
Cancer

Difficulty Swallowing Hiatal Hernia Gastric or Duodenal Ulcer Diverticulitis  
Diabetes Frequent Hunger Frequent Thirst Frequent Urination (more than 3 times  
overnight) Gout Thyroid Kidney Stones Gall Stones Blackened Stool  
Constipation Blood in Urine Prostate Hypertrophy Liver Disease STD'S HIV  
Hepatitis

Fatigue Weakness Difficulty Walking Phlebitis Pain in Calf (at rest or when  
walking) Leg cramps Osteoporosis Phlebitis Osteoarthritis Fibromyalgia  
Paralysis Numbness/Burning/Tingling in Feet/Hands Shaking Tremors Multiple  
Sclerosis Polio Anxiety Difficulty Healing Scar Easily Rheumatoid Arthritis

**VITAL SIGNS**

**BLOOD PRESSURE      PULSE      RESPIRATIONS      TEMPERATURE**