



# Adult Medical History Update

CH# \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Physicians Name \_\_\_\_\_ City/State \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Reason \_\_\_\_\_

## Have you ever had:

- heart disease.....  No  Yes
- chest pains/angina.....  No  Yes
- heart attack.....  No  Yes
- heart murmur/defect.....  No  Yes
- mitral valve prolapse.....  No  Yes
- rheumatic fever.....  No  Yes
- artificial joints/implants.....  No  Yes
- pacemaker.....  No  Yes

- high/low blood pressure.....  No  Yes
- fainting/dizziness.....  No  Yes
- stroke.....  No  Yes
- neurologic/nervous disorder.....  No  Yes
- epilepsy.....  No  Yes
- Bell's palsy.....  No  Yes
- MS/multiple sclerosis.....  No  Yes

- anxiety/depression.....  No  Yes
- muscular disorder.....  No  Yes
- muscular dystrophy.....  No  Yes

- lung disease.....  No  Yes
- TB/tuberculosis.....  No  Yes
- asthma/emphysema.....  No  Yes
- "hayfever"/sinus infection.....  No  Yes

- kidney/bladder problems.....  No  Yes
- stomach/GI problem.....  No  Yes
- colitis/diverticulitis.....  No  Yes

- ulcers.....  No  Yes
- esophageal reflux.....  No  Yes
- bulimia/anorexia.....  No  Yes

- diabetes(high sugar).....  No  Yes
- hypoglycemia(low sugar).....  No  Yes
- thyroid problems.....  No  Yes
- arthritis/rheumatism.....  No  Yes
- prolonged steroid medications.....  No  Yes

- tumor/cancer.....  No  Yes
- radiation/chemotherapy.....  No  Yes
- excessive bleeding.....  No  Yes
- blood/platelet disorder.....  No  Yes
- leukemia.....  No  Yes
- skin disease.....  No  Yes
- ear/eye trouble.....  No  Yes

- liver disease/jaundice.....  No  Yes
- hepatitis.....  No  Yes
- herpes infection.....  No  Yes
- syphilis/gonorrhea/VD.....  No  Yes
- immune system problems.....  No  Yes
- HIV/AIDS.....  No  Yes
- Lupus.....  No  Yes

- Do you smoke?.....  No  Yes
- Use chewing tobacco/snuff?.....  No  Yes

## Are you allergic to:

- Anesthetics.....  No  Yes
- Penicillin.....  No  Yes
- Erythromycin.....  No  Yes
- Tetracycline.....  No  Yes
- Aspirin.....  No  Yes
- Ibuprofen.....  No  Yes
- Tylenol.....  No  Yes
- Codeine.....  No  Yes
- Latex.....  No  Yes
- Metals.....  No  Yes
- Other \_\_\_\_\_

Are you pregnant? #months \_\_\_\_\_ Due date \_\_\_\_\_

Major surgery for: \_\_\_\_\_

Stay in hospital for: \_\_\_\_\_

Now under care of physician for \_\_\_\_\_

List current medications	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

I have answered these questions to the best of my ability. I will notify the office of any changes in this information at the earliest possible time.

Signature \_\_\_\_\_ Date \_\_\_\_\_