Medical History Questionnaire

(Please fill in all circles completely)

Name: _____ Birth Date: ___/___/___

E-mail Address: _____ Phone Number: _____

Who were you referred by?_____

What is the reason for today's visit? _____

Are you allergic to any medications? (If yes, list meds and reactions below) □ yes

If yes, describe:

_____

Have you ever had a reaction to local anesthetic (i.e novacaine, lidocaine), bandages, latex, or topical antibiotics (Neosporin) □ yes

If yes, describe:

_____

Please list below current medications you are taking (including prescriptions, over the counter meds, vitamins, herbal supplements, aspirin):

_____

_____

Emergency Contact: _____ phone number: _____

Have you ever had a history of:

Pacemaker	No/Yes	Herpes/Cold Sores	No/Yes
Defibrillator	No/Yes	Dark spots after pregnancy	No/Yes
Fainting	No/Yes	Keloids	No/Yes
Hepatitis	No/Yes	Polycystic Ovary Disease	No/Yes
Diabetes	No/Yes	Easy bleeding/bruising	No/Yes
Thyroid Disease	No/Yes	Bleeding disorders	No/Yes
HIV/AIDS	No/Yes	Irregular periods	No/Yes
Convulsions, Epilepsy, Seizures	No/Yes	Autoimmune disease	No/Yes
Cancer (type:_____)	No/Yes	Glaucoma	No/Yes
Skin Cancer	No/Yes	Heart Disease	No/Yes
Asthma	No/Yes	Myasthenia Gravis	No/Yes
Joint Replacement	No/Yes	ALS	No/Yes
Metal Plates	No/Yes		

Social History

Do you now or have you ever used oral/patch contraceptives?	No/Yes
Are you trying to conceive?	No/Yes
Are you breastfeeding?	No/Yes
Are you a smoker?	No/Yes
Are you pregnant?	No/Yes