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Bethlehem, PA 18020

Medical History Update

_____ ____ _____ _____
FIRST NAME **M.I.** **LAST NAME** **DATE**

CURRENT ADDRESS: _____ **HOME PHONE:** _____
CITY, STATE, ZIP: _____ **CELL PHONE:** _____
EMAIL: _____ **WORK PHONE:** _____

PHYSICIAN'S NAME: _____ **PHONE #:** _____
When was your last visit to your physician? _____
When was your last complete physical? _____
Hospitalizations since last visit? _____
Under a physician's care now for: _____

Please tell us if you have had any of the following by checking the appropriate box:

HEALTH HISTORY Do you currently have, or have you ever had, any of the following conditions?

☐ **AIDS/HIV POSITIVE**
☐ **ALZHEIMER'S DISEASE**
☐ **ANAPHYLAXIS**
☐ **ANEMIA**
☐ **ANGINA**
☐ **ARTHRITIS/GOUT**
☐ **ARTIFICIAL JOINT**
☐ **ASTHMA**
☐ **ATOPIC (ALLERGY PRONE)**
☐ **BACK PROBLEMS**
☐ **BLOOD DISEASE**
☐ **BLOOD TRANSFUSION**
☐ **BREATHING PROBLEM**
☐ **BRUISE EASILY**
☐ **CANCER**
☐ **CHEMOTHERAPY**
☐ **CHEMICAL/ SUBSTANCE**
☐ **DEPENDENCY**
☐ **CHEST PAINS**
☐ **COLD SORES/FEVER BLISTERS**
☐ **CONGENITAL HEART DISORDER**
☐ **CONVULSIONS**
☐ **CORTISONE MEDICINE**
☐ **DEPRESSION**
☐ **DIABETES**
☐ **DRUG ADDICTION**
☐ **EAR CONGESTION**
☐ **EASILY WINDED**
☐ **EATING DISORDERS**
☐ **EXCESSIVE BLEEDING**
☐ **EXCESSIVE THIRST**
☐ **FAINTING SPELLS/DIZZINESS**
☐ **FEVER BLISTERS/COLD SORES**
☐ **FREQUENT COUGH**
☐ **FREQUENT DIARRHEA**
☐ **GENITAL HERPES**
☐ **GLAUCOMA**
☐ **HAY FEVER**
☐ **HEADACHES/MIGRAINES**
☐ **HEART ATTACK/FAILURE**
☐ **HEART MURMUR**
☐ **HEART PACEMAKER**
☐ **HEART TROUBLE/DISEASE**
☐ **HEMOPHILIA**
☐ **HEPATITIS A**
☐ **HEPATITIS B or C**
☐ **HERPES**
☐ **HIGH BLOOD PRESSURE**
☐ **HIVES OR RASHES**
☐ **HUMAN PAPILLOMA VIRUS (HPV)**
☐ **HYPOGLYCEMIA**
☐ **IRREGULAR HEARTBEAT**
☐ **JOINT REPLACEMENT**
☐ **KIDNEY PROBLEMS**
☐ **LEUKEMIA**
☐ **LIMITED JAW OPENING**
☐ **LIVER DISEASE**
☐ **LOW BLOOD PRESSURE**
☐ **NECK PAIN**
☐ **PAIN IN JAW JOINTS**
☐ **PARATHYROID DISEASE**
☐ **PSYCHIATRIC CARE**
☐ **RADIATION TREATMENTS**
☐ **RECENT WEIGHT LOSS**
☐ **RENAL DIALYSIS**
☐ **RHEUMATIC FEVER**
☐ **RHEUMATISM**
☐ **SCARLET FEVER**
☐ **SHINGLES**
☐ **SICKLE CELL ANEMIA**
☐ **SINUS TROUBLE**
☐ **SLEEP APNEA**
☐ **SPINA BIFIDA**
☐ **STOMACH/INTESTINAL**
☐ **DISEASE**
☐ **STROKE**
☐ **SURGICAL IMPLANTS**
☐ **SWELLING OF LIMBS/ANKLES**
☐ **THYROID DISEASE**
☐ **TINNITUS/RINGING IN EAR**
☐ **TONSILLITIS**
☐ **TUBERCULOSIS**
☐ **TUMORS OR GROWTHS**
☐ **ULCERS**
☐ **VENEREAL DISEASE**
☐ **YELLOW JAUNDICE**

☐ **EMPHYSEMA**
☐ **ENDOCARDITIS**
☐ **EPILEPSY OR SEIZURES**
☐ **LUNG DISEASE**
☐ **MITRAL VALVE PROLAPSE**
☐ **MOUTH PIERCINGS**

Have you recently started TOBACCO, ALCOHOL, SPECIAL DIET, RECREATIONAL DRUGS? (Please circle)

Please list any ALLERGIES TO Drugs, Medications or Anesthetics: _____

_____

_____

_____

Please list any other MEDICAL CONDITIONS not mentioned above: _____

_____

_____

_____

Please list all DRUGS/MEDICATIONS that you currently take: _____

_____

_____

_____

_____

_____ _____

PATIENT SIGNATURE **DATE**