



Past Medical History Information

Patient's Name: _____ Today's Date: _____

Social Security Number: _____ Date of Birth: _____

Primary Care Physician: _____ Date of last exam: _____

Have you ever been hospitalized? Yes _____ No _____

If yes, what for? _____

Please check Yes if you have or No if you do not have each of the medical conditions listed.

- Angina (heart pain) Yes _____ No _____
- Hypertension (high blood pressure) Yes _____ No _____
- Diabetes (high blood sugar) Yes _____ No _____
- Renal Disease (kidney disease) Yes _____ No _____
- Respiratory Illness (lung problems) Yes _____ No _____
- Bleeding Disorder Yes _____ No _____
- Seasonal Allergies Yes _____ No _____
- HIV/AIDS Yes _____ No _____
- Cancer Yes _____ No _____
- Sinus Problems Yes _____ No _____
- Recent Viral Illness (flu-like illness) Yes _____ No _____
- Currently Pregnant Yes _____ No _____
- Currently Breast-feeding Yes _____ No _____
- Tendency to getting cold sores Yes _____ No _____

Please describe any current or past medical condition or treatment not listed above:

Please list your past surgeries: _____

Do you currently smoke or chew tobacco? Yes _____ No _____ If no, have you in the past? Yes _____ No _____

How many packs per day? _____

Do you drink alcohol, beer, or wine? Yes _____ No _____ If no, have you in the past? Yes _____ No _____

How often? _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient's Signature: _____ Today's Date: _____