PAST MEDICAL HISTORY

PLEASE CHECK

_____ Diabetes	_____ Asthma	_____ Heart Disease	_____ High Blood Pressure
_____ Anemia	_____ Arthritis	_____ Epilepsy	_____ Bleeding Disorder
_____ Gout	_____ Stomach Ulcers	_____ Blood Clots	_____ Kidney Problems
_____ Liver Problems	_____ Tuberculosis	_____ Cancer	_____ High Cholesterol
_____ Lung Problems	_____ Thyroid	_____ Stroke	_____ Circulatory Problems
_____ Hepatitis	_____ HIV/AIDS	_____ Other	

What SURGERIES have you had? _____

What MEDICATIONS do you take regularly? (Include prescriptions, over-the-counter medications and vitamins.)

_____

_____

Do you have any ALLERGIES to MEDICATIONS? Yes _____ No _____

If yes, what are they? _____

INSURANCE

Who is responsible for this account? _____ Relationship to patient: _____

Insurance Company: _____

Subscriber Name: _____ Relationship to patient: _____

Subscriber's Birth date: _____ SS# _____

Member ID # _____ Group # _____

Is patient covered by additional insurance? _____ Yes _____ No

Insurance Company: _____

Subscriber Name: _____ Relationship to patient: _____

Subscriber's Birth date: _____ SS# _____

Member ID # _____ Group # _____

Patient Name _____

Please continue ->