UPDATED MEDICAL HISTORY

PLEASE UPDATE ALL OF THE FOLLOWING DEMOGRAPHIC INFORMATION:

Name _____ Date_____
First Middle Last Preferred Name

Mailing Address _____ City _____State _____ Zip _____

Cell # _____Home # _____Work # _____Emergency #_____

Email _____Soc. Security # _____Birthdate _____Employer:_____

I accept text and/or e-mail communications. Yes No

PLEASE COMPLETE ALL OF THE FOLLOWING: (you can use the back of this form to provide any additional information if needed):

Yes No Are you taking any medication? **List:** _____

Yes No Are you allergic to any medication? **List:** _____

Yes No Are you or have you taken medication for osteoporosis? **List:**_____

Yes No Do you have a history of a major illness? **List:**_____

Yes No Have you ever had surgery or been hospitalized? **List:** _____

Yes No Do you use any form of tobacco? **List:** _____

Yes No Do you have any allergies? (medications, materials, etc?) **List:** _____

PLEASE ANSWER YES/NO TO <u>ALL 3 COLUMNS</u> BELOW:

Yes / No Abnormal Bleeding	Yes / No Hemophilia	Yes / No Thyroid Problems
Yes / No Alcohol Abuse	Yes / No Heart Problems	Yes / No Tuberculosis
Yes / No Anemia	Yes / No Heart Surgery	Yes / No Ulcers
Yes / No Angina Pectoris	Yes / No Hepatitis A, B, or C (circle type)	Yes / No Autism/Sensory Issue _____
Yes / No Arthritis	Yes / No High Blood Pressure	
Yes / No Artificial Heart Valve	Yes / No Joint Replacement Date of replacement:_____	
Yes / No Asthma	Yes / No Kidney Disease	
Yes / No Blood Transfusion	Yes / No Liver Disease	
Yes / No Cancer	Yes / No Low Blood Pressure	
Yes / No Chemotherapy	Yes / No Mitral Valve Prolapse	**FOR FEMALES ONLY:**
Yes / No Colitis	Yes / No Pacemaker	*Are you pregnant? If so, how many weeks?
Yes / No Congenital Heart Defect	Yes / No Mental /Mood Disorders	_____
Yes / No Diabetes	Yes / No Radiation Therapy	*Are you nursing?_____
Yes / No Drug Abuse	Yes / No Rheumatic Fever	*Are you taking Birth Control Pills? _____
Yes / No Emphysema	Yes / No Seizures	
Yes / No Epilepsy	Yes / No Sexually Transmitted Disease	
Yes / No Fainting Spells	Yes / No Shingles	
Yes / No Fever Blisters	Yes / No Sickle Cell Disease	
Yes / No Glaucoma	Yes / No Sinus Problems	
Yes / No HIV or AIDS	Yes / No Stroke	

For any YES marked above, please describe specific condition further:_____

_____

X_____ _____

Signature of patient (or parent, if minor) **Date**