Medical History Update

LAST NAME: FIRST NAME: Birthdate:

Name of Medical Doctor: City/State:

Emergency Contact: Phone: Relationship:

ARE YOU TAKING ANY MEDICATIONS? Y N

List all current medications you take:

birth control

Are you allergic to any of the following?

Y	N				
☐	☐	Aspirin	☐	☐	Iodine
☐	☐	Codeine	☐	☐	Latex
☐	☐	Ibuprofen	☐	☐	Penicillin/ Amoxicillin
☐	☐	Anesthetic	☐	☐	Sulfa

Other:_____

NO KNOWN ALLERGIES _____

Do you have any of the following medical conditions?

Y	N				
☐	☐	Mitral Valve Prolapse	☐	☐	Bleeding Problems
☐	☐	Diabetes	☐	☐	Kidney Disease
☐	☐	Heart Murmur	☐	☐	Liver Disease
☐	☐	Heart Trouble	☐	☐	Psychiatric Treatment
☐	☐	High Blood Pressure	☐	☐	Sinus Trouble
☐	☐	Joint Replacement	☐	☐	Stroke
☐	☐	Heart Pace Maker	☐	☐	Ulcers
☐	☐	High Cholesterol	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Epilepsy or Seizures
			☐	☐	Aids/HIV positive
			☐	☐	Cancer

WOMEN: Are you pregnant? Y N Expected due date:_____

Tobacco use? Y N Marijuana use? Y N If yes, what kind and how much?_____

Any other conditions we should know about? Y N _____

Date:

Signature_____ Doctor Signature_____