Medical History Survey

Patient's Name:_____

Name of Physician:_____
Physician's phone # or Clinic name:_____

PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOU PAST OR PRESENT MEDICAL STATUS

__ Rheumatic fever
__ Angina/chest pains
__ High blood pressure
__ Headaches
__ Tuberculosis
__ Seizures/ convulsions
__ Psychiatric treatment
__ Ulcer
__ Jaundice
__ Kidney disease
__ HIV positive
__ Arthritis
__ Recreational drug use
__ Artificial implants or grafts
__ Heart murmur
__ Heart attack
__ Heart valve prosthesis
__ Sinus trouble
__ Asthma
__ Stroke
__ Alcoholism
__ Colitis
__ Diabetes
__ Venereal disease
__ AIDS
__ Fibromyalgia
__ Glaucoma
__ Joint replacement
__ Congenital heart defects
__ Pacemaker
__ Mitral valve prolapse
__ Cancer
__ Emphysema
__ Anemia
__ Hemophilia
__ Hepatitis, type_____
__ Thyroid disease
__ Prolonged bleeding
__ ARC
__ Earaches
__ Depression
__ Whiplash injury

Women only:
__ Currently pregnant
__ Birth control pills

I an currently allergic to:
__ Penicillin
__ Other antibiotics
__ Latex
__ Other _____
__ Codeine
__ Aspirin
__Local anesthetic
__ Metals (ie: nickel)

__ I have been under the care of a physician or have been hospitalized in the past two years.

__ I have a disease, condition, or problem not listed that you should know about.

__ I am currently taking the following medications or drugs (please include herbs, vitamins and other natural remedies):_____
_____
_____
_____

I certify that the above information is correct to the best of my knowledge.
I will notify Dr. Moberly's office of any changes as they occur.

_____
Signature Date