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 ALL 3 COLUMNS BELOW:

Yes / No Abnormal Bleeding
Yes / No Alcohol Abuse
Yes / No Anemia
Yes / No Angina Pectoris
Yes / No Arthritis
Yes / No Artificial Heart Valve
Yes / No Asthma
Yes / No Blood Transfusion
Yes / No Cancer
Yes / No Chemotherapy
Yes / No Colitis
Yes / No Congenital Heart Defect
Yes / No Diabetes
Yes / No Drug Abuse
Yes / No Emphysema
Yes / No Epilepsy
Yes / No Fainting Spells
Yes / No Fever Blisters
Yes / No Glaucoma
Yes / No HIV or AIDS

Yes / No Hemophilia
Yes / No Heart Problems
Yes / No Heart Surgery
Yes / No Hepatitis A, B, or C (circle type)
Yes / No High Blood Pressure
Yes / No Joint Replacement Date of replacement:________________________
Yes / No Kidney Disease
Yes / No Liver Disease
Yes / No Low Blood Pressure
Yes / No Mitral Valve Prolapse
Yes / No Pacemaker
Yes / No Mental /Mood Disorders
Yes / No Radiation Therapy
Yes / No Rheumatic Fever
Yes / No Seizures
Yes / No Sexually Transmitted Disease
Yes / No Shingles
Yes / No Sickle Cell Disease
Yes / No Sinus Problems
Yes / No Stroke

Yes / No Thyroid Problems
Yes / No Tuberculosis
Yes / No Ulcers
Yes / No Autism/Sensory Issue _____________

FOR FEMALES ONLY:

*Are you pregnant? If so, how many weeks?
____

*Are you nursing?________________________________

*Are you taking Birth Control Pills? __________________

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

X____ ____

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