



MEDICAL HISTORY

Patient's Name:

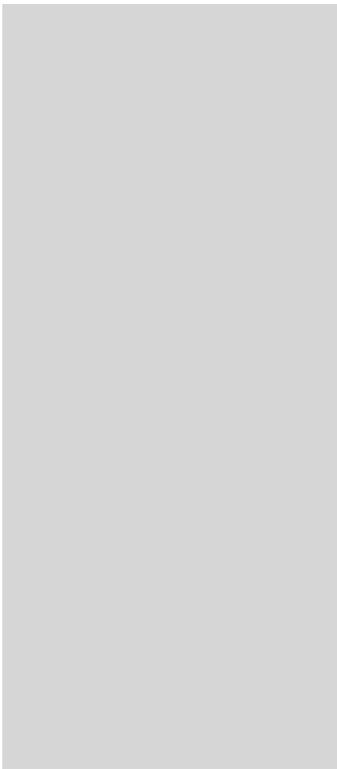
First \_\_\_\_\_ Middle Initial \_\_\_\_\_
Last \_\_\_\_\_

Comments

- 1. Physician's Name \_\_\_\_\_
2. Are you under a physician's care? YES NO
Since when? \_\_\_\_\_
Why? \_\_\_\_\_
3. When was your last complete physical? \_\_\_\_\_
4. Are you taking any medications or substances? YES NO
(If yes, please list medications in comments section.) YES NO
5. Do you routinely take health related substances? YES NO
6. Are you allergic to any medications or substances? YES NO
7. Do you have any other allergies? YES NO
8. Do you have any problems with penicillin, antibiotics,
anesthetics, or other medications? YES NO
9. Are you allergic to latex? YES NO
10. Are you allergic to metal? YES NO
11. Are you pregnant or suspect you may be? YES NO
12. Do you use birth control medication? YES NO
13. Do you have heart problems? YES NO
14. Do you have a pacemaker or artificial heart valve
implant? YES NO
15. Have you ever had rheumatic fever? YES NO
16. Are you aware of any heart murmurs? YES NO
17. Do you have HIGH or LOW blood pressure? YES NO
18. Have you ever had a serious illness or major surgery? YES NO
(If yes, please explain in the comments section.)
19. Have you ever had a radiation treatment, chemo,
treatment for tumor, growth or other condition? YES NO
20. Do you have inflammatory diseases, such as arthritis
or rheumatism? YES NO
21. Do you have any artificial joints / prosthesis? YES NO
22. Do you have blood disorders, such as anemia or
leukemia? YES NO
23. Have you ever bled excessively after being cut or
injured? YES NO
24. Do you have any stomach problems? YES NO

Large grey rectangular area for handwritten comments.

- |   |     |    |
|---|-----|----|
| 25. Do you have any kidney problems?  | YES | NO |
| 26. Do you have any liver problems?   | YES | NO |
| 27. Are you diabetic?   | YES | NO |
| 28. Do you have asthma?   | YES | NO |
| 29. Do you have epilepsy or seizure disorders?                                    | YES | NO |
| 30. Do you, or have you, had a venereal disease?                                  | YES | NO |
| 31. Have you tested HIV positive?   | YES | NO |
| 32. Do you have Hepatitis?  | YES | NO |
| 33. Do you, or have you, had Tuberculosis (TB)?                                   | YES | NO |
| 34. Do you smoke, chew, use snuff or any form of tobacco?                         | YES | NO |
| 35. Have you ever used any weight loss products?                                  | YES | NO |
| 36. Do you have any diseases, conditions, or problems not listed?                 | YES | NO |
| (If so, please explain in the comments section.)                                  |     |    |
| 37. Is there anything else we should know about your health that was not covered? | YES | NO |
| 38. Do you want to privately speak to Dr. Irby about a problem?                   | YES | NO |



**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.**

**Patient / Guardian's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_