Patient Medical Information Sheet

Patient's name_____Birthdate_____Today's date_____

1. Please list any medications that the patient is allergic to, and explain what the reaction was (e.g. rash, facial swelling, vomiting, etc):

Penicillin	No	Yes	_____
Sulfa	No	Yes	_____
Other antibiotics	No	Yes	_____
Novacaine	No	Yes	_____
Other(Please list and explain):			_____
			_____

2. Please list all medications that the patient has taken in the past 48 hours and takes routinely (include any "homeopathic" type of meds): _____

_____

_____

3. Is there a family history of , or has the patient ever had a problem with prolonged bleeding after surgery or an injury?
No Yes If yes, please explain:_____

_____

4. Has the patient ever had, or does he/she have: If yes, please explain:

Heart trouble	No	Yes
Heart murmur	No	Yes
Asthma	No	Yes
Wheezing	No	Yes
Pneumonia	No	Yes
Tuberculosis	No	Yes
High blood pressure	No	Yes
Diabetes	No	Yes
Seizure, convulsion	No	Yes
Jaundice	No	Yes
Hepatitis	No	Yes
Arthritis, swollen joints	No	Yes
Blood transfusion	No	Yes
Anemia	No	Yes
Allergy, hayfever	No	Yes

5. Has the patient ever been hospitalized? No Yes If yes, please list the reason, approximate date, and which hospital: _____

_____

_____

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Patient's name_____Birthdate_____Today's date_____

Current weight_____

6. Has the patient ever undergone surgery? No Yes If yes, please list the reason, approximate date, and which hospital and surgeon:_____
_____
_____
_____

Patient referred by:_____

Patient's managing physician (Pediatrician, Internist, Family Physician, etc.)_____

Other physicians or health-care professionals involved in patient's care:_____
_____
_____
_____
_____

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