Dr. Lawrence Busch

MEDICAL HISTORY

Patient Name____Date____________________

Are you under a physician's care now? ____Yes No
Why?_______________________ Physicians name?_______________ Phone__________________

Have you ever been hospitalized or had a major operation? _________________________________Yes No
Discuss ____

Have you ever had a serious injury to your head or neck? ___________________________________Yes No

Are you taking any medications, aspirin, vitamins, herbals, or drugs? _____ ______________________Yes No
Please list medications: ____

Are you on a special diet? __ Discuss ____Yes No

Are you allergic to any medications or substances? ______________________________________Yes No
Please List: ____

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to you appointment….premedication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Condition			Bruise Easily			Osteoporosis			Arthritis/Fibromyalgia		
Excessive Bleeding			Anemia			Aredia Reclast Zometa			Rheumatism		
HeartMurmur/Defect*			Sickle Cell Disease			Fosamax Actonel Boniva			Pain in Jaw Joints		
Irregular Heart Beat			Hemophilia			Diabetes			Cortisone Medicine		
Heart Attack/Failure			Methemoglobinemia			Excessive Thirst			Artificial Joint *		
Angina/Chest Pain			Leukemia			Hypoglycemia			Nervousness		
Mitral valve Prolapse*			Recent Blood Transfusion			Liver Disease			Sleep Apnea		
Scarlet Fever			Swelling of Limbs			Hepatitis A, B or C			Drug Addiction/Alcoholism		
Rheumatic Fever*			Lung Disease			Yellow Jaundice			Sexually Transmitted Disease		
Artificial Heart Valve*			Breathing Problems			Kidney Problems			Aids/HIV		
Heart Pace Maker*			Frequent Cough			Renal Dialysis			Glaucoma		
Pulmonary Shunt *			Asthma			Thyroid Disease			Fainting or Dizziness		
High Blood Pressure			Emphysema			Parathyroid Disease			Psychiatric Care		
Bacterial Endocarditis*			Tuberculosis			Tumors or Growths			Alzheimer's Disease		
Coronary Stent*			Sinus Trouble			Cancer			Cochlear Implants		
Stroke			Stomach Disease			Radiation Treatments			Need Premedication		
Epilepsy or Seizures			Cold Sores/Herpes			Chemotherapy			Hives or Rash		

Have you ever had any other serious illness not checked above? Discuss ______________________Yes No
Do you wish to talk privately about any problem? ____
X____Date _____________
Patient Signature (Parent or Guardian)

Reviewed By Doctor____________________________________Date_________BP_______Pulse________
History Review and Significant Findings ____