Confidential Patient Medical History *(Please Print)*

Compass Point

DR. Yezerski

Indicate if you have had any of the following: Check the appropriate box

Herpes	☐ Yes ☐ No	Glaucoma/Contacts/Vision Problems	☐ Yes ☐ No
Convulsions (Seizures) Epilepsy, Stroke	☐ Yes ☐ No	Prolonged Bleeding	☐ Yes ☐ No
TMJ/Jaw Clicking	☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Asthma/Bronchitis	☐ Yes ☐ No	Thyroid Problem	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Recent Cough or Cold	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Heart Disease/Surgery	☐ Yes ☐ No	Bone or Joint Disease/Replacement	☐ Yes ☐ No
Heart Murmur/Rheumatic Fever	☐ Yes ☐ No	Recreational Drug Use/Chemical or	
Mitral Valve Prolapse/Artificial Heart Valve	☐ Yes ☐ No	Alcohol Dependency	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No
Stomach Trouble (Ulcer)	☐ Yes ☐ No	Psychiatric Therapy	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No
Hepatitis (Jaundice)	☐ Yes ☐ No	Women: are you pregnant or nursing?	☐ Yes ☐ No

Have you been under a physicians care during the past 5 years? ☐ Yes ☐ No

If yes, for what? _____

Date of your last physical exam: _____

Your physician: _____

Have you ever been hospitalized for sickness or surgery? ☐ Yes ☐ No

If yes, for what? _____

Do you take any prescription medication or over-the-counter drugs? ☐ Yes ☐ No

Specify: _____

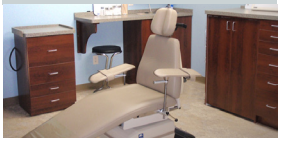
Is there any other information that should be known about your health? ☐ Yes ☐ No

Specify: _____

I hereby certify that the above information is true and correct.

_____ _____ _____

Signature of Patient, Parent or Guardian | Witness | Date



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