Dr. Gordon D. Black Inc. **Please Complete in Full** **Medical History 2022**

Full Legal Name		**Preferred / Nickname**
Date of Birth (M/D/Y)		**Email**
Cell Phone		**Home Phone**
Address	**City**	**Postal Code**
Occupation	**Employer**	
Medical Doctor	**Last Medical Appt**	**Purpose**
Emergency Contact (name)	**Phone**	**Relationship**

Medications taken in last 2 years:	**Allergies to** Latex? Antibiotics ?
	Other Allergies

YES	NO	For EVERY Question	YES	NO	For EVERY Question
☐	☐	Rheumatic Fever – Date:	☐	☐	Diabetes Type **1**_____ or Type **2** _____
☐	☐	Artificial Heart Valve	☐	☐	Stomach or Duodenal Ulcer
☐	☐	Congenital Heart Disease	☐	☐	Digestive Disorders _____
☐	☐	Heart Problems – not listed above	☐	☐	Arthritis
☐	☐	Artificial Joint Hip ____ Knee _____	☐	☐	Glaucoma
Surgery Date _____			☐	☐	Head or Neck Injuries
☐	☐	Anemia or Other Blood Disorder	☐	☐	Epilepsy, Convulsions, Seizures
☐	☐	Systemic Lupus Erythematosus	☐	☐	Hives, Skin Rashes, Hay Fever
☐	☐	Organ Transplant	☐	☐	Hepatitis - Type _____
☐	☐	Blood Pressure High ____ or Low____	☐	☐	HIV / AIDS
☐	☐	Stroke - Date _____	☐	☐	Cancer - Type _____
☐	☐	Lung Disease	☐	☐	Tumour or Abnormal Growth
☐	☐	Emphysema	☐	☐	Radiation Therapy - Date_____
☐	☐	Tuberculosis	☐	☐	Chemotherapy - Date_____
☐	☐	Asthma	☐	☐	Currently Taking Blood Thinners
☐	☐	Sinus Problems	☐	☐	User of Tobacco Products
☐	☐	Kidney Disease	☐	☐	Snoring or Sleep Apnea
☐	☐	Liver Disease	☐	☐	Using CPAP or Snore Appliance
☐	☐	Thyroid or Parathyroid Disease	☐	☐	MALES: Prostate Disorder
☐	☐	Osteoporosis	☐	☐	FEMALE: Taking Oral Contraceptives
☐	☐	Dementia / Alzheimer's	☐	☐	FEMALES: Pregnant - Due _____
☐	☐	Auto-Immune Disease _____			

Have you been Hospitalized in the last 2 years? If, Yes please provide details:

_____

_____

Signature:_____ Date:_____