MEDICAL HISTORY

Date: ___/___/___

Patient's Name ____ Age: ______

What brings you to our office? ____

____

Have you been a patient in a hospital in the last two years? Yes No

Has a physician treated you in the last year? Yes No

Doctor's name: ____

Have you taken any prescribed medications or drugs in the last two years? Yes No

Please list all medications or drugs:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Are you, or have you ever been on any weight reduction medicine (e.g. Fen-Phen)?

Yes No

Do you smoke tobacco, or use smokeless tobacco? Yes No

Have you ever had a problem with dental, local or general anesthetic? Yes No

Circle if you are allergic to any of the following:

Penicillin	Sulfa	Antibiotics	Codeine
Iodine	Aspirin	Local Anesthetics	Latex Gloves

Other: ____

Are you allergic (i.e. itching, rash, swelling) to or made sick by any drugs, medications, or doctors treatment? Yes No

____

(OVER)

Circle if you have ever had any of the following:

Heart Disease	Stroke	Glaucoma
Heart Attack	Kidney Trouble	Pain in Jaw Joints
Angina	Ulcers	Allergies or Hives
High Blood Pressure	Emphysema	Hepatitis
Low Blood Pressure	Tuberculosis (TB)	Liver Disease
Heart Murmur	Asthma	Yellow Jaundice
Mitral Valve Prolapse	Hay Fever	Drug or Alcohol Addiction
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Scarlet Fever	AIDS or HIV Infection	Hemophilia
Artificial Heart Valve	Diabetes	Venereal Disease
Heart Pacemaker	Thyroid Disease	Epilepsy or Seizures
Congenital Heart Defects	Cancer	Nervousness
Heart Surgery	Leukemia	Sickle Cell Disease
Prosthetic Joint	Cortisone Medication	Bruise Easily
Anemia	Radiation Treatment	Psychiatric Treatment
	Chemotherapy	Fainting or Dizzy Spells
	Arthritis	
	Rheumatism	

Do you have any disease, condition or problem not listed? Yes No

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Women: Are you pregnant now? Yes No

Do you anticipate becoming pregnant? Yes No

Are you taking birth control medication? Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will inform the doctor at the next appointment without fail.

____________________ Patient's Signature

____________________ Doctor's Signature

____________________ Date