MEDICAL HISTORY

Patient:_____ Date taken:_____

Are you allergic to any medications? ☐ **Yes** ☐ **No** If Yes, please list:

1. _____ 2. _____

List all medications you are currently taking: 1. _____

2. _____ 3. _____

4. _____ 5. _____

History of Diseases

Do you have now, or have you ever had diseases or conditions of:

Lungs:

Bronchitis	☐ **Yes** ☐ **No**
Emphysema	☐ **Yes** ☐ **No**
Asthma	☐ **Yes** ☐ **No**
Chronic Cough	☐ **Yes** ☐ **No**
Morning Cough	☐ **Yes** ☐ **No**
Tuberculosis	☐ **Yes** ☐ **No**

Vascular:

High Blood Pressure	☐ **Yes** ☐ **No**
Chest Pain	☐ **Yes** ☐ **No**
Heart Attack	☐ **Yes** ☐ **No**
Heart Murmur	☐ **Yes** ☐ **No**
Irregular Heart Beat	☐ **Yes** ☐ **No**
Pacemaker	☐ **Yes** ☐ **No**
Phlebitis	☐ **Yes** ☐ **No**

Other Systemic:

Diabetes	☐ **Yes** ☐ **No**
Thyroid	☐ **Yes** ☐ **No**
Kidney	☐ **Yes** ☐ **No**
Bladder	☐ **Yes** ☐ **No**
Stomach	☐ **Yes** ☐ **No**
Bowel	☐ **Yes** ☐ **No**
Hepatitis or Yellow Skin	☐ **Yes** ☐ **No**
Glaucoma	☐ **Yes** ☐ **No**
Arthritis/Joint Deformity	☐ **Yes** ☐ **No**
Convulsions, Epilepsy/Seizures	☐ **Yes** ☐ **No**
Fainting	☐ **Yes** ☐ **No**
Lupus	☐ **Yes** ☐ **No**
Cancer	☐ **Yes** ☐ **No**

What type? _____

Do you drink alcohol?	☐ **Yes** ☐ **No**	If Yes, how many drinks per day? _____
Do you smoke?	☐ **Yes** ☐ **No**	If Yes, how many packs per day? _____
Do you use IV drugs?	☐ **Yes** ☐ **No**	If Yes, what? _____ How much? _____

Have you had or have you been exposed to HIV (AIDS)?	☐ **Yes** ☐ **No**
Have you ever had dental anesthesia (Novacaine or Lidocaine)?	☐ **Yes** ☐ **No**
If yes, have you had a reaction to the anesthesia?	☐ **Yes** ☐ **No**
Do you usually pre-medicate prior to a dental procedure?	☐ **Yes** ☐ **No**
Do you bleed easily?	☐ **Yes** ☐ **No**
(Women) Are you pregnant?	☐ **Yes** ☐ **No**

If yes, Due Date: _____

Skin:

When you are exposed to the sun do you:	☐ **Tan only** ☐ **Tan & Burn** ☐ **Burn**
Have you ever had skin cancer?	☐ **Yes** ☐ **No**
Has anyone in your family had skin cancer?	☐ **Yes** ☐ **No**
Do you have a history of any specific skin diseases?	☐ **Yes** ☐ **No**

If yes, please list: _____

List any other diseases or conditions we should know about : _____

List any surgical procedures you have had in the last 6 months:

1. _____
2. _____
3. _____

Reviewed by: _____, Physician _____ Date