

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

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

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

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