MEDICAL HISTORY

Name: ________________________ Date of Birth: ___/___/___ Gender: ☐ Male ☐ Female

Primary Care Physician: ______________________________ Phone (____)____________

Address:______________________________________ Date of Last Physical: _______________

Are you presently under the care of a physician? ☐ Yes ☐ No

List all medications that you are taking, including vitamins ________________________________

____

Have you ever been hospitalized? (if yes reason(s) and date) ______________________________

____

What surgeries have you had, if any? ____

____

Have you ever been advised by a physician of the need for any type of surgery or treatment, if so, please list

____

WOMEN: Are you pregnant, suspect you are, or nursing? ___________________________________

Do you have, or have you ever had: (check those that apply)

☐ Artificial Heart Valve	☐ Hemophilia	☐ Persistant Cough	☐ Chemical Dependency
☐ Congenital Heart Defects	☐ High or Low Blood Pressure	☐ Cough up blood	☐ Psychiatric Care
☐ Fainting Spells	☐ Prolonged Bleeding	☐ Herpes Simplex	☐ Tobacco Habit
☐ Heart Murmur	☐ Glaucoma	☐ Hepatitis	☐ Cancer
☐ Heart Problems	☐ Kidney Disease	☐ Tuberculosis	☐ Chemotherapy
☐ Mitral Valve Prolapse	☐ Liver Disease	☐ Venereal Disease	☐ Radiation Therapy
☐ Rheumatic Fever	☐ Skin Rash	☐ Arthritis	☐ Asthma
☐ Scarlet Fever	☐ Ulcer	☐ Artificial Joints or Implants	☐ Hay Fever
☐ Swelling of Ankles	☐ Cortisone or Steroid Therapy	☐ Back Problems	☐ Respiratory Disease
☐ Anemia	☐ Diabetes	☐ Jaw Pain	☐ Shortness of Breath
☐ Blood Disease	☐ Thyroid Problems	☐ Epilepsy	☐ Tonsillitis
☐ Circulatory Problems	☐ HIV or AIDS	☐ Headaches or Migranes	☐ Allergies

If you have drug allergies please elaborate:

☐ Penicillin ☐ Sulfa ☐ Erythromycin ☐ Asprin ☐ Codeine ☐ Other ______________________

Has your physician ever advised you to take antibiotics before dental treatment? ☐ Yes ☐ No

Do you use tobacco, cigarettes, pipe, cigar, chewing? ☐ Yes ☐ No

If yes, type of tobacco used and quantity ______________________________________

Do you drink the following? ☐ Coffee ☐ Tea ☐ Alcohol ☐ Soda ☐ Diet Soda

If yes to any, list quantity and consumption for one week ___________________________

Do you participate in recreational drugs? ☐ Yes ☐ No

If yes, how often? ____

Describe your eating habits ____

Is there anything else we should know about your medical history? ___________________

Patient Signature ________________________________ Date ______________________

Patient File Number

Patient Name

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