MEDICAL HISTORY

Patient's Name: _____ Date of Birth: _____ Email: _____

Your Physician: _____ Type of Physician:_____ How Long:_____

City, State:_____ Phone #:_____

DO YOU HAVE OR HAVE YOU EVER HAD: (circle)

1. Hospitalization for illness or surgery in last 5 years	Yes	No	28. Shortness of breath on mild exertion	Yes	No
2. An allergic reaction	Yes	No	29. Chest pains on mild exertion	Yes	No
3. Any reaction to:			30. Hives, skin rash, hay fever	Yes	No
a. aspirin	Yes	No	31. Asthma	Yes	No
b. penicillin	Yes	No	32. Emotional problems or tension	Yes	No
c. erythromycin	Yes	No	33. Psychiatric treatment	Yes	No
d. tetracycline	Yes	No	34. A tumor or abnormal growth	Yes	No
e. codeine	Yes	No	35. Radiation treatment by cobalt, radium x-ray etc.	Yes	No
f. sedatives or sleeping pills (barbiturates)	Yes	No	36. Glaucoma	Yes	No
g. dental anesthetic	Yes	No	37. Contact lenses	Yes	No
h. latex	Yes	No	38. Prostate disorders (if male)	Yes	No
i. other	Yes	No	39. AIDS (Acquired Immune Deficiency Syndrome)	Yes	No
4. Hepatitis	Yes	No	40. AIDS related diseases	Yes	No
5. Jaundice (yellow skin and eyes)	Yes	No	41. Blood transfusion	Yes	No
6. Epilepsy	Yes	No	42. Cosmetic lip or facial fillers	Yes	No
7. Arthritis	Yes	No	43. Herpes	Yes	No
8. Sexually transmitted disease	Yes	No	44. History of drug or alcohol abuse	Yes	No
9. Rheumatic fever	Yes	No	45. HPV Gardasil vaccine	Yes	No
10. Scarlet fever	Yes	No	**ARE YOU:**		
11. Anemia or other blood disorders	Yes	No	1. Presently being treated for any illness	Yes	No
12. Prolonged bleeding due to a slight cut	Yes	No	2. Now taking any medication	Yes	No
13. Kidney disease	Yes	No	3. Aware of a change in you general health	Yes	No
14. Diabetes	Yes	No	4. Aware of any recent weight change	Yes	No
15. Stomach disorder or acid reflux	Yes	No	5. Often thirsty	Yes	No
16. Liver disease	Yes	No	6. Urinating more than six times per day	Yes	No
17. Tuberculosis	Yes	No	7. Often exhausted and fatigued	Yes	No
18. Emphysema	Yes	No	8. Subject to frequent headaches	Yes	No
19. Thyroid or parathyroid disorders	Yes	No	9. Smoker, or using any tobacco products	Yes	No
20. Heart condition	Yes	No	10. Generally a nervous person	Yes	No
21. Heart murmur	Yes	No	11. Often unhappy and depressed	Yes	No
22. A Pacemaker / Defibrillator	Yes	No	12. Taking any naturopathic meds or supplements	Yes	No
23. Arteriosclerosis	Yes	No	13. Using a C-Pap Device	Yes	No
24. High blood pressure	Yes	No	**IF FEMALE, ARE YOU NOW:**		
25. Low blood pressure	Yes	No	1. Pregnant or nursing	Yes	No
26. An artificial valve or joint placed. Have you discussed with your physician the need for pre-medicating?	Yes	No	2. Taking birth control pills or other hormones	Yes	No
			3. Presently in menopause	Yes	No
27. A stroke	Yes	No	4. Past menopause	Yes	No

PLEASE EXPLAIN FULLY ANY "YES" ANSWERS ABOVE:

_____

_____

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IF THERE ARE ANY CHANGES IN MY MEDICAL HISTORY, I WILL NOTIFY THE DENTIST.

Patient Signature: _____ Today's Date:_____

Medical History Update:

Date:	Reviewed By:	Comments:	Patient Initial:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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