

MEDICAL HISTORY

NAME _____ AGE _____ DOB _____ HEIGHT _____ WEIGHT _____

Physician Office _____ Last Physical _____

REFERRING DENTIST _____ Last Visit _____

DO YOU HAVE OR HAVE YOU EVER HAD?

(Circle those that apply, write in others.)

Oral/Dental: (inflamed areas, growths, sore spots, pain in jaw, loose teeth, removable dental appliance)
 Yes No

Eye, ear, nose, throat problems: (glaucoma, lens implant, sinus problems, hay fever, contact lenses)
 Yes No

Heart problems: (chest pain, angina, heart attack, congestive heart failure, irregular heart beat, pacemaker, heart valve replacement, damage, prolapse or heart murmur, rheumatic fever, heart bypass surgery)
 Yes No

Lung problems: (asthma, emphysema, tuberculosis, bronchitis, chronic cough, abnormal chest x-ray, sleep apnea)
 Yes No

Vascular problems: (high blood pressure, low blood pressure, leg bypass surgery)
 Yes No

Intestinal problems: (acid reflux, hiatal hernia, hepatitis, cirrhosis, ulcers, intestinal bleeding)
 Yes No

Genitourinary problems: (kidney disease or failure, dialysis, prostate problems)
 Yes No

Could you be pregnant? Are you nursing?
 Yes No

Muscle/bone problems: (back problems, neck problems, arthritis, TMJ, joint problems, artificial joints)
 Yes No

Skin problems: (rash, hives, open sores)
 Yes No

Nervous system problems: (seizures, paralysis, numb areas, stroke, weakness, migraines, confusion, fainting, anxiety, depression, bipolar disease, dementia, Alzheimer's, autism)
 Yes No

Endocrine problems: (diabetes, thyroid, low blood sugar)
 Yes No
If diabetic, controlled by: diet, oral medications, insulin

Anemia, bleeding problems, transfusions, anti-coagulant therapy
 Yes No

Immune system problems: (rheumatoid arthritis, lupus, HIV)
 Yes No

Cancer/Chemotherapy/X-Ray Treatment
 Yes No When _____

ALLERGIES None

Are you allergic to, or have you ever had an adverse reaction to:

• Latex or rubber products? Yes No

• Other allergies to medications? Please list:

Medication _____ Reaction _____

Medication _____ Reaction _____

Medication _____ Reaction _____

MEDICATIONS Please list: None

(Include over the counter and herbal medications)

_____ dose/freq. _____

_____ dose/freq. _____

_____ dose/freq. _____

_____ dose/freq. _____

PREVIOUS SURGERIES/HOSPITALIZATIONS/YEAR

Anesthetic problems/family history/muscle weakness/high fevers after anesthesia Yes No

IMMUNIZATIONS

Tetanus/year Yes No

Hepatitis B/year Yes No

PERSONAL/SOCIAL HISTORY

Do you now or have you ever used:

Tobacco/Chew

Yes: Packs per day? _____ Number of years? _____ No

Quit date? _____

Alcohol

Yes: # per day? _____ Last drink? _____ No

Recreational/Street Drugs

Yes Quit date? _____ No

FAMILY HISTORY

Mother healthy? Yes No (explain)

Father healthy? Yes No (explain)

DO YOU HAVE any other disease, condition or problem, not listed above that you think the doctor should know about?

Yes (Explain) _____ No

Signature of Person Completing Health History

Date

Doctor's Initials

Date

MEDICAL UPDATE: I have reviewed my Health History and confirm that it adequately states past and present conditions.

Exceptions or Changes

Date

Patient's Signature

Doctor's Initials

Exceptions or Changes

Date

Patient's Signature

Doctor's Initials

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.