Medical History Form

Name: ______________________________ Date: ______________________

Age: _____ Sex: M F Weight: ____ Height: ____ Date of Last Physical Exam: ______________________

(Please check all the apply)

Consumption of the following:

Tobacco ☐ Amount: ______________ Aspirin ☐ Amount: ______________

Alcohol ☐ Amount: ______________ Vitamins ☐ Amount: ______________

Allergies:

Drug Allergies? ☐ List: ______________________________

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Latex Allergy? ☐ Tape Allergy? ☐ Anesthesia Allergy? ☐

Medications *List dose or number of pills taken per day*

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Family History

Abnormal Bleeding? ☐ Abnormal Clotting? ☐ Anesthetic Problems? ☐ Cancer? ☐ Blood Clots? ☐

Please describe: ______________________________

____

Bleeding Problems

Bruise or bleed easily? ☐

Abnormal clotting? ☐

Have you ever had a blood transfusion? ☐

Have you ever been exposed to?

Intravenous Drugs? ☐

HIV/Aids? ☐

Infectious Diseases? ☐

Do you wear?

Contact Lenses? ☐

Dentures? ☐

Crowns/Veneers/Caps/Bonding? ☐

Cardiac Review

Angina ☐ High Blood Pressure ☐ Heart Murmur ☐ Irregular heart beat ☐ Heart Attack ☐

Hypertension ☐ Scarlet Fever ☐ Rheumatic Fever ☐ Mitral Valve ☐

Heart Disease ☐ *If yes, Explain:* ______________________________

Chest Pain/Shortness of Breath ☐ *If yes, Explain:* ______________________________

Other ☐ *If yes, Explain:* ______________________________

Neurological Review

Stroke ☐ Migraine ☐ Epilepsy ☐ Seizures ☐

Fainting/Blackout Spells ☐ *If yes, Explain:* ______________________________

Other ☐ *If yes, Explain:* ______________________________

Respiratory Review

Asthma? ☐ Emphysema? ☐ Tuberculosis? ☐ Pneumonia? ☐

Lung Disease? ☐ *If yes, Explain:* ______________________________

Other ☐ *If yes, Explain:* ______________________________

Endocrine Review

Diabetes? ☐ *If yes, Explain:* ______________________________

Thyroid Disease? ☐ *If yes, Explain:* ______________________________

Other ☐ *If yes, Explain:* ______________________________

Genito-Urinary Review

Kidney Stones ☐ Bladder Infections ☐

Kidney Disease ☐ *If yes, Explain:* ______________________________

Other ☐ *If yes, Explain:* ______________________________

Gastro-Intestinal Review

Stomach Ulcers ☐ Gastritis ☐ Colitis ☐

Gallbladder Disease? ☐ *If yes, Explain:* ______________________________

Other ☐ *If yes, Explain:* ______________________________

Other

Glaucoma ☐ Arthritis ☐ Anemia ☐ Rheumatoid Arthritis ☐ Pregnant ☐

Autoimmune Disease ☐ *If yes, Explain:* ______________________________

Cancer ☐ *If yes, Explain:* ______________________________

Liver Disease ☐ *If yes, Explain:* ______________________________

Hepatitis (A B or C) ☐ *If yes, Explain:* ______________________________

Other ☐ *If yes, Explain:* ______________________________

Difficulties with Local or General Anesthesia? ☐

Medical Problems or Conditions now under treatment by a Physician? ☐

If so, explain: ______________________________

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List all surgeries/hospitalizations with dates:

Surgeries/Hospitalizations	Date