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: _____

_____

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

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

_____

_____

_____

Family History

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

Please describe: _____

_____

Bleeding Problems		**Have you ever been exposed to?**		**Do you wear?**	
Bruise or bleed easily?	☐	Intravenous Drugs?	☐	Contact Lenses?	☐
Abnormal clotting?	☐	HIV/Aids?	☐	Dentures?	☐
Have you ever had a blood transfusion?	☐	Infectious Diseases?	☐	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:* _____

-OVER-

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: _____

_____

_____

List all surgeries/hospitalizations with dates:

Surgeries/Hospitalizations	**Date**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Which phamacy do you use?_____ Phone Number_____

Patient Signature _____ Date_____

I HAVE REVIEWED MEDICAL HISTORY WITH PATIENT _____Date _____

Signature of Pre Operative Nurse