PATIENT MEDICAL HISTORY

Patient Name:

If female please answer the following:

Y N

☐ ☐ Are you taking Birth Control Pills?

☐ ☐ Are you pregnant? If Yes, # of weeks

☐ ☐ Are you nursing?

Please answer the following:

Height:	
Weight:	

Conditions

☐ ☐ Asthma
☐ ☐ Allergies
☐ ☐ Sinus Problems
☐ ☐ Chronic Cough
☐ ☐ Abnormal Bleeding
☐ ☐ Hemophilia
☐ ☐ Anemia
☐ ☐ Sickle Cell Disease
☐ ☐ Arthritis
☐ ☐ Cancer- Chemotherapy
☐ ☐ Radiation Therapy
☐ ☐ Colitis
☐ ☐ Cosmetic Surgery
☐ ☐ Diabetes
☐ ☐ Eating Disorder
☐ ☐ Difficulty Breathing
☐ ☐ Emphysema
☐ ☐ Tuberculosis
☐ ☐ Epilepsy
☐ ☐ Seizures
☐ ☐ Stroke
☐ ☐ Fever Blisters

Conditions

☐ ☐ Frequent Headaches
☐ ☐ Glaucoma
☐ ☐ Angina Pectoris
☐ ☐ Heart Attack
☐ ☐ Heart Surgery
☐ ☐ High Blood Pressure
☐ ☐ Low Blood Pressure
☐ ☐ Congenital Heart Defect
☐ ☐ Mitral Valve Prolapse
☐ ☐ Artificial Heart Valve
☐ ☐ Heart Murmer
☐ ☐ Congestive Heart Failure
☐ ☐ Pace Maker
☐ ☐ Rheumatic Fever
☐ ☐ Venereal Disease
☐ ☐ HIV+ AIDS
☐ ☐ Kidney Problems
☐ ☐ Hepatitis (A, B, Or C)
☐ ☐ Liver Disease
☐ ☐ Psychiatric Problems
☐ ☐ Shingles
☐ ☐ Thyroid Problems

Conditions

☐ ☐ Ulcers
☐ ☐ Joint Replacement
☐ ☐ Tobacco Use
☐ ☐ Recreational Drug Use
☐ ☐ Daily Alcohol Use
☐ ☐ Immunosuppressive Drugs

Y N **Allergies**

☐ ☐ Aspirin
☐ ☐ Codeine
☐ ☐ Dental Anesthetics
☐ ☐ Erythromycin
☐ ☐ Jewelry
☐ ☐ Latex
☐ ☐ Metals
☐ ☐ Penicillin
☐ ☐ Tetracycline

Other

____

____

____

Medications:	Taken for what condition:	Dosage:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above?**
If yes, please describe below...