PATIENT MEDICAL HISTORY

Rev 02/20/15

Patient Name_____ DOB_____ Date_____

Primary Care Physician_____ Phone_____ Date of Last Phys. Exam_____

Emergency Contact_____ Phone _____ Relationship to Patient_____

Preferred Pharmacy_____ Phone_____

Please circle an answer for <u>each</u> question below:

Yes	No	**Have you experienced any change in your health in the past two years?**
Yes	No	**Are you currently under the care of a physician?** If yes, describe your treatment:
Yes	No	**Have you had any medical treatment or physician visit of any kind in the past two years?** Please describe:
Yes	No	**Have you ever had any surgical operation of any kind?** If yes, describe:
Yes	No	**Were you transfused during any surgical operation?**
Yes	No	**Have you been advised by a physician of the need for any type of surgery or treatment?** For what?
Yes	No	**Have you been told that you need to pre-medicate prior to dental work?** If yes, describe:

Do you have, have you had, or have you been treated for, any of the following:

Yes	No	**Arthritis**	Yes	No	**Thyroid Condition**	Yes	No	**Epilepsy, Seizures**
Yes	No	**Rheumatic Fever**	Yes	No	**Kidney Disorder**	Yes	No	**Fainting Spells**
Yes	No	**Heart Problems**	Yes	No	**Ulcers**	Yes	No	**Ear Infections**
Yes	No	**Mitral Valve Prolapse**	Yes	No	**Hepatitis/ Liver Disease**	Yes	No	**Chronic Sinus**
Yes	No	**High Blood Pressure**	Yes	No	**Enzyme Deficiency**	Yes	No	**Tuberculosis**
Yes	No	**Low Blood Pressure**	Yes	No	**Chronic Diarrhea**	Yes	No	**Asthma / Hay fever**
Yes	No	**Heart Murmur**	Yes	No	**Diabetes**	Yes	No	**Allergy**
Yes	No	**Pacemaker – Type:**	Yes	No	**Hemophilia, Bleeding or Blood Disorders**	Yes	No	**Radiation or Chemical Therapy**
Yes	No	**Hydrocephalus**	Yes	No	**Anemia, Sickle Cell Disease**	Yes	No	**Hip or Joint Replacement**
Yes	No	**Hypothermia**	Yes	No	**Venereal Disease, Herpes II**	Yes	No	**Chemical Dependency**
Yes	No	**Anorexia, Bulimia**	Yes	No	**HIV /AIDS/ AIDS Related Complex**			

Yes	No	**Have you ever had an allergic reaction or been told not to take any medication?** If yes, describe:
Yes	No	**Do you wear contact lenses?**
Yes	No	**Do you use any tobacco product?** Daily intake:
Yes	No	**Are you pregnant?** Anticipated delivery date:
Yes	No	**Are you currently taking any prescription drugs of any kind? (**Example: Birth control, hormone, diet, etc.) **If yes, Please list - attach a separate sheet if required**
Yes	No	**Are, you currently taking any non-prescription drugs of any kind?** (Include aspirin, cough syrup, nasal spray, recreational drugs, sugar, caffeine, vitamins, and over the counter supplements, etc.) **Please list - attach a separate sheet if required.**

What is your baseline blood pressure?

S_____/D_____/_____

I certify the above to be true and correct to the best of my knowledge

Signature:_____ Date:_____

Patient, Parent or Legal Guardian