MEDICAL HISTORY FORM

NAME_____DATE_____

HT._____WT._____

Reason for today's visit:_____

HEALTH INFORMATION: (Your answers are for our records only and are confidential)

1. YES NO Has there been any changes in your health within the past year?

2. My last physical exam was on_____

3. YES NO Are you now under the care of a physician(s)? If so, for what condition(s)? _____
   _____
   _____

4. Name/phone of my physician(s):_____
   _____
   _____

5. Do you have or have you **ever** had **any** of the following:

   YES NO Rheumatic heart disease or Congenital heart defect
   YES NO Mitral valve prolapse
   YES NO Cardiovascular disease (Heart trouble, heart attack, coronary artery disease, high blood pressure, atrial fib, heart murmur, stroke)
   YES NO Do you have chest pain upon exertion?
   YES NO Are you short of breath after mild exercise?
   YES NO Heart surgery, valve replacement, bypass surgery, angioplasty, stent, pacemaker

   YES NO Asthma
   YES NO Sinus or nasal problems
   YES NO Respiratory problems, Emphysema, COPD, Bronchitis, Tuberculosis
   YES NO Obstructive sleep apnea
   YES NO Fainting spells or seizures, convulsions, epilepsy, dizziness
   YES NO Diabetes

   YES NO Hepatitis A, B, C, Jaundice, or Liver disease
   YES NO HIV, AIDS, or ARC
   YES NO Osteoarthritis, Rheumatoid arthritis, Psoriasis, Lupus
   YES NO TMJ problem, clicking/popping of jaw, difficulty opening mouth, ever used a night guard?
   YES NO Stomach ulcers, Reflux, Hiatal hernia
   YES NO Kidney trouble, Kidney stones, Dialysis

   YES NO Cancer, Radiation treatment, Chemotherapy
   YES NO Bleeding disorder, anemia, bleeding tendency, blood transfusion
   YES NO Using blood thinners, such as Aspirin, Coumadin, Plavix, Eliquis?
   YES NO Osteoporosis, osteopenia; ever taken Fosamax, Boniva, Actonel, Xgeva, Prolia?
   YES NO Cortisone, Prednisone, Steroid therapy
   YES NO Any disease, drug, or transplant surgery that has depressed your immune system?

   YES NO Do you smoke or chew tobacco? How many a day?_____
   YES NO Do you drink alcohol? How often?_____
   YES NO Do you use controlled substances? If so, what? _____

6. Please list your current medications:_____
_____
_____
_____
_____

7. Are you allergic or have you reacted adversely to:

YES	NO	Penicillin	YES	NO	Sulfite preservatives
YES	NO	Sulfa	YES	NO	Latex
YES	NO	Codeine	YES	NO	Soy/Eggs
YES	NO	Iodine	Other:_____		
YES	NO	Aspirin/Ibuprofen	Other:_____		

8. YES NO Have you had any trouble associated with dental treatment? If so, explain:_____
_____
_____

9. YES NO Any disease, condition, or problem not listed above that the doctor should know about? If so, explain:
_____
_____

10. Please list previous surgeries and/or hospitalizations (date):_____
_____
_____
_____
_____

11. YES NO Would you like to discuss any other issues with the doctor?

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible:

Signature:_____Date:_____