Patient Name: ______________________________________ Age: __________

MEDICAL HISTORY

1. When was your last physical exam: ______________________________

2. Physician Name ______________________________
   Address ______________________________

3. Have you been a patient in the hospital during the past two years? . . . . . . ☐ YES ☐ NO
   If yes, for what reason? ______________________________

4. Have you been under the care of a medical doctor during the past two years? . . . . . . ☐ YES ☐ NO
   If yes, for what reason? ______________________________

5. Have you taken any prescription medication during the past 12 months? . . . . . . ☐ YES ☐ NO

6. Are you allergic to (i.e., itching, rash, swelling, of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications. . . . . . . ☐ YES ☐ NO
   If yes, please list: ______________________________

7. Are you allergic to any anesthetic? . . . . . . ☐ YES ☐ NO

8. Have you ever had any excessive bleeding requiring special treatment? . . . . . . ☐ YES ☐ NO

9. Check any of the following which you have had or have at present:

☐ Heart Failure	☐ Stroke	☐ Thyroid Disease	☐ Yellow Jaundice
☐ Heart Disease or Attack	☐ Kidney Trouble	☐ X-Ray or Cobalt Treatment	☐ Blood Transfusion
☐ Angina Pectoris (Chest Pain)	☐ Ulcers	☐ Chemotherapy (Cancer, Leukemia)	☐ Drug Addiction
☐ High Blood Pressure	☐ Bleeding Disorders	☐ Arthritis	☐ Hemophilia
☐ Heart Murmur	☐ Shortness of Breath	☐ Rheumatism	☐ Venereal Disease (Syphilis, Gonorrhea)
☐ Rheumatic Fever	☐ Emphysema	☐ Cortisone Medication	☐ Cold Sores or Fever Blisters
☐ Congenital Heart Lesions	☐ Cough	☐ Glaucoma	☐ Genital Herpes
☐ Scarlet Fever	☐ Tuberculosis (TB)	☐ Pain in Jaw Joints	☐ Epilepsy or Seizures
☐ Artificial Heart Valve	☐ Asthma	☐ Cosmetic Surgery	☐ Fainting or Dizzy Spells
☐ Heart Pacemaker	☐ Hay Fever	☐ HIV Positive (AIDS)	☐ Nervousness
☐ Heart Surgery	☐ Sinus Trouble	☐ Hepatitis A (Infectious)	☐ Psychiatric Treatment
☐ Artificial Joint	☐ Allergies or Hives	☐ Hepatitis B (Serum)	☐ Sickle Cell Disease
☐ Anemia	☐ Diabetes	☐ Liver Disease	☐ Bruise Easily

10. Do you smoke? How much? ______________________________ ☐ YES ☐ NO

11. Do you drink alcoholic beverages? . . . . . . ☐ YES ☐ NO

12. Do you use recreational drugs? . . . . . . ☐ YES ☐ NO

13. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? . . . . . . ☐ YES ☐ NO

14. Do your ankles swell during the day? . . . . . . ☐ YES ☐ NO

15. Have you lost or gained more than 10 pounds in the last year? . . . . . . ☐ YES ☐ NO

16. Do you use more than two pillows to sleep? . . . . . . ☐ YES ☐ NO

17. Do you ever wake up from sleep short of breath? . . . . . . ☐ YES ☐ NO

18. Are you on a special diet? . . . . . . ☐ YES ☐ NO

19. Has your medical doctor ever said you have a cancer or tumor? . . . . . . ☐ YES ☐ NO

20. Do you have any disease, condition or problem not listed? . . . . . . ☐ YES ☐ NO

21. List all medications you are taking at this time: ______________________________ ☐ YES ☐ NO

22. Women: Are you pregnant? ☐ YES ☐ NO If yes, what month are you due? ______________________________
    Are you taking birth control pills? . . . . . . ☐ YES ☐ NO

(You should be aware that research has shown that certain antibiotics may alter the effectiveness of birth control pills)

____
I certify that the above information is complete and accurate

______________________________ ______________
PATIENTS SIGNATURE (if child, signature of responsible person) Date

MEDICAL/DENTAL HISTORY- 1