MEDICAL HISTORY

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Med
- ☐ Allergy-Environment
- ☐ Allergy-Medications
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Pressure-High
- ☐ Blood Pressure-Low
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation/Chemo
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ STD/HPV
- ☐ Stomach Issues/Ulcer
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Other - Explain Below

_____

_____

☐ Subject to frequent headaches ☐ Tobacco/Alcohol Use ☐ Vaping Use ☐ Marijuana Use
☐ FEMALE: Pregnant or Planning Pregnancy ☐ FEMALE: Nursing ☐ Other Drug Use _____

If any conditions or alerts selected above need further clarification, please describe below. Please enter due date if pregnant.

_____

_____

What is your estimate of your general health? ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Do you take antibiotic premedication for your dental visits? If yes, please explain below* ◯ Yes ◯ No

Pre-Med: _____

Are you taking any medications (prescription or non-prescription) including regular doses of aspirin or birth control pills? If yes, please list below. ◯ Yes ◯ No

_____

_____

Medication for Osteoporosis? ◯ Yes ◯ No Other _____

Do you have any allergies (including allergies to medications)? If yes, please explain below* ◯ Yes ◯ No

Allergies: _____

_____

Name of your Physician and Phone Number: _____

_____

Name and phone number of Preferred Pharmacy: _____

_____

Describe any current medical treatment, recent hospitalizations and recent or impending surgery: _____

_____

By signing this form, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

Patient Signature _____ *Date* _____