MEDICAL HISTORY (Confidential)

Patient's Name _____ Birthdate _____
FIRST MIDDLE LAST

Physician's Name (M.D.) _____ Address _____

Approximate DATE of last physical examination _____

	YES	NO
1. Are you <u>now</u> undergoing <u>current</u> medical treatment?	❑	❑
3. Are you now <u>pregnant</u> or suspect you may be?	❑	❑
4. Have you been sick from, shown an <u>allergy</u> to, or told not to take:		
a. Aspirin, codeine or other pain medications?	❑	❑
b. Novocaine, Lidocaine or other anesthetics?	❑	❑
c. Penicillin or other antibiotics?	❑	❑
5. Do you have any <u>METAL allergies</u>? (Skin reactions to inexpensive jewelry)	❑	❑
6. Do you have any allergy to LATEX?	❑	❑
7. Do you have any history of narcotic abuse (this may effect our Novocaine).	❑	❑
8. Are you <u>now</u> taking any medications? (of any kind)	❑	❑

Explanations

Do you now have, or have you had, any of the following?	Have Now	Have Had	NO
9. Heart disease	❑	❑	❑
10. Heart attack	❑	❑	❑
11. Rheumatic Fever, or Rheumatic Heart Disease	❑	❑	❑
12. Heart murmur or heart defect from birth	❑	❑	❑
13. Chest pains or angina pectoris	❑	❑	❑
14. DIABETES	❑	❑	❑
15. Shortness of breath when resting (or with minimal activity)	❑	❑	❑
16. High blood pressure	❑	❑	❑
17. Stroke	❑	❑	❑
18. Arthritis	❑	❑	❑
19. Fainting spells, convulsions or epilepsy	❑	❑	❑
20. Liver disease (jaundice or cirrhosis, etc.)	❑	❑	❑
21. Hepatitis: A, B, or C	❑	❑	❑
22. Kidney disease or infection	❑	❑	❑
23. Lung disease (TB, emphysema, asthma, etc.)	❑	❑	❑
24. Venereal disease (gonorrhea, syphilis, herpes, etc.)	❑	❑	❑
25. AIDS, HIV Positive or AIDS-Related-Complex	❑	❑	❑
26. Ulcers	❑	❑	❑
27. Nervous breakdown or severe emotional problems	❑	❑	❑
28. Thyroid disorder	❑	❑	❑
29. Blood disorder (anemia or other)	❑	❑	❑
30. Are you taking blood thinners (e.g. Coumadin)	❑	❑	❑
31. Cancer or other tumor	❑	❑	❑
32. Do you smoke, chew, use snuff or any other <u>tobacco</u> product	❑	❑	❑
33. Does an MD want you to take antibiotic for dental treatment?	❑	❑	❑
34. Is there anything of importance in your medical history that has not been asked? (If YES, <u>please explain</u> in box on right)	❑	❑	❑

NOTE: If you would like to speak to the Doctor privately about any problem, please feel free to ask him personally.

HEALTH CHANGES _____ _____
_____ _____ _____
_____ _____ _____

The above medical questions have been answered accurately.

Signature _____ Date _____ Relationship to Patient _____