MEDICAL HISTORY AND QUESTIONAIRE

Name________________/____/___________________________ Date_________________________

Do you have, or have you had, any of the following? Please check all that apply.

Heart Concerns_________________________ □
Chest pain_________________________ □
Shortness of breath__________________ □
Blood pressure problem High/Low_____ □
Heart murmur______________________ □
Rheumatic fever____________________ □
Pacemaker_________________________ □
Artificial heart valve_________________ □
What medications do you take to control These conditions?___________________
Dosage:__________________________
Do you premed for any of these conditions?
What medicine do you premed with?______
____
Blood Concerns__________________________ □
Easy bruising_______________________ □
Frequent nose bleeds_________________ □
Abnormal bleeding___________________ □
Blood disease(anemia)________________ □
Ever require a blood transfusion?________ □
Allergy concerns__________________________ □
Hay fever__________________________ □
Sinus problems______________________ □
Skin rashes_________________________ □
Taking allergy medication______________ □
Asthma_________________________________ □
Asthma meds_________________________ □
Shortness of breath____________________ □
Tuberculosis or other Respiratory disease_______ □
Intestinal Concerns________________________ □
Ulcers______________________________ □
Weight gain or loss____________________ □
Special diet__________________________ □
Constipation/Diarrhea__________________ □
Kidney or bladder problems_____________ □
What medications do you take for these issues
____
Dosage_______________________________
Bone or Joint concerns______________________ □
Arthritis______________________________ □
Back or neck pain______________________ □
Joint replacement(total hip,pins or implants)_ □
Do you require premed for this?___________ □
If So, what type?________________________
Fainting spells,Seizures,or Epilepsy_____________ □
What medications do you take for these issues
____
____
Dosage_______________________________
Frequent or severe headaches__________________ □
What medications do you take for these issues
____
Dosage_______________________________
Thyroid Concerns___________________________ □
What medications do you take for this________
____
Dosage_______________________________
Persistent cough or swollen glands_______________ □

Diabetes-Type________________________ □
Urinate more than 6 times a day______ □
Thirsty or mouth dry a lot__________ □
Family History of diabetes__________ □
Cancer/Tumor_________________________ □
Do drink alcohol_______________________ □
If so, how much?__________________ □
Do you smoke?_________________________ □
If so, how much?__________________ □
Do you use smokeless tobacco?___________ □
Hepatitis/Type__________________________ □
Jaundice or liver trouble________________ □
Herpes or other STD___________________ □
HIV-Positive/AIDS____________________ □
Glaucoma____________________________ □
Do you wear contact lenses______________ □
History of head injury_________________ □
Epilepsy or other neurological disease_____ □
History of alcohol or drug abuse___________ □
Do you have any disease,condition or problem not listed previously that you feel we should know about?___________________________ □
If so, please describe____________________
____
Do you take a daily aspirin?_______________ □
Please list any medications or supplements that you haven't already listed and dosage_______
____
____
____
Are you allergic to or have you reacted adversely to any of the following?
Local anesthetics("novacaine")__________ □
Penicillin or other antibiotics____________ □
Sulfa drugs_____________________________ □
Barbiturates,sedatives, or sleeping pills____ □
Aspirin,acetaminophen,or ibuprofen______ □
Codeine,Demerol,or other narcotics_______ □
Reaction to metals____________________ □
Latex or rubber dam___________________ □
Other_____________________________ □
What were your symptoms______________

Women:
Are you taking contraceptives or other hormones___________________________ □
Are you pregnant?___________________ □
If so, delivery date_________________
Are you nersing?___________________ □