

Oneal Russell, DDS, LLC
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(410) 263- 4300

Section VIII:

Medical History

Please indicate if you have a history of the following medical conditions:

Abnormal bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fever blister	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sickle cell	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus prob.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hayfever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid issue	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial bones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial heart/valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis (A/B/C)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer/chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Yellow jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other conditions not listed:		
Cosmetic surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Difficulty breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		

Do you have any have any medical conditions that need further clarification: Yes No

If yes, please explain: _____

Are you now currently under the care of a physician? Yes No If yes, please explain: _____

Name of physician: _____ Phone: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

Women only:

Pregnant: Yes No If yes, how many weeks: _____ Due date: _____

Taking birth control pills: Yes No

Nursing: Yes No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: _____

 Signature of patient, parent or guardian