Patient Medical/Dental History Form

NAME: _____ ***DATE:*** _____

MEDICAL HISTORY

Please Circle Appropriate Response:

NO YES **Are you in good general health?**

NO YES Are you now taking any drugs or medications?

Which ones?_____

_____

_____

NO YES Are you allergic to any medications?

Which ones? _____

_____

_____

Family Doctor:_____

Phone:_____

_____

NO YES Would you object to our office contacting your family doctor in regard to any medical problem that may arise?

_____

NO YES Have you ever received local anesthesia (Novocaine or Xylocaine) by a dentist or doctor?

NO YES Have you ever received general anesthesia?

NO YES Have you ever had any adverse reaction to either local or general anesthesia?
Please describe_____

NO YES Do you take blood thinners?
Which ones? _____

NO YES Do you take vitamins regularly?
Which ones?_____

NO YES Do you take vitamins containing Vitamin E?

NO YES Do you take aspirin products or anti-inflammatory medicines or headache medicines?
Which ones?_____

NO YES Do you exercise regularly?

PLEASE LIST ALL PREVIOUS SURGERIES AND DATES:

_____

_____

DO ANY FAMILY MEMBERS HAVE: (Circle if yes)

Heart trouble
Excessive scarring
Diabetes
Adverse reactions to anesthesia
Tuberculosis
Excessive bleeding tendency
Psychiatric or "nerve" problems

HAVE YOU HAD:

NO YES Blood pressure or related problems
NO YES Liver, gallbladder, problems
NO YES "yellow Jaundice", Hepatitis problems
NO YES Heart trouble
NO YES Kidney disease
NO YES Diabetes
NO YES Stomach problems, indigestion or ulcers
NO YES Bleeding tendency or excessive bruising
NO YES Any part of your body paralyzed or numb
NO YES Psychiatric consultation
NO YES Epilepsy-convulsions or seizures
NO YES Broken bones of the face, neck, jaw or back
NO YES Back trouble
NO YES Abnormal chest x-rays
NO YES Abnormal Electrocardiogram (ECG)
NO YES Asthma or other respiratory problems
NO YES Any medical treatment for nervous condition
NO YES Excessive scarring
NO YES Tuberculosis
NO YES Thyroid problems
NO YES Any other illnesses. If so please list:
NO YES A gain or loss of more than 15 pounds in your body weight.
NO YES Abdominal or inguinal hemia
NO YES History of blood clots in legs or lungs
NO YES History of legs swelling
NO YES Glaucoma, cataracts
NO YES Dry eyes
NO YES Herpes or Cold Sores

Other:_____

DO YOU:

NO YES Wear contact lenses
NO YES Have dentures, false teeth, caps or bridges
NO YES Smoke? How much? _____
NO YES Drink alcohol? How much? _____
NO YES Think you are pregnant? Date of last menstrual period_____
NO YES Have any contagious or infectious condition
NO YES Have you been exposed directly or indirectly to any one with HIV (AIDS)

The above information is strictly confidential

_____ _____

Patient Signature Date Witness Signature Date