Medical History Form

Name: _____ **Date**: _____

Preferred name/nickname: _____

Address: _____

Phone: (cell) _____ (home or work) _____

Date of Birth: _____ **Sex:** M/F **Height:** ____ **Weight:** _____

SS#: _____ **Marital Status:** _____

Email Address: _____

Emergency Contact: _____ **Phone**: _____

Date of last physical exam: _____

Physician Name/Address/Phone: _____

Have you had any SURGERIES/OPERATIONS in last 5 years? Y/N

If so, list here with date: _____

List of current medications? _____

_____

List any ALLERGIES: _____

Latex allergy? Y/N

Ever had abnormal bleeding with previous extraction/surgery? Y/N

If yes, explain: _____

Do you get short of breath or have chest pain after exercise? Y/N

Do your legs, ankles, or feet swell? Y/N

Do you have diabetes? Y/N

If yes, which type? Insulin dependent? Last HbA1C and blood glucose level reading? _____

Do you smoke, chew, or vape? Y/N **How much/day?** _____

Do you drink alcohol? Y/N **How much/week?** _____

Do you need to take an antibiotic before dental visits? Y/N
If so, why? _____

Please circle any of the following which you have or have had:

Heart Attack/Disease	Asthma	Crohn's Disease
Angina	Emphysema	Epilepsy
Artificial Heath Valve	COPD	Fainting, Dizzy
Pacemaker	Tuberculosis	Hemophilia
Heart Surgery	Sinus Problems	Liver Disease
High Blood Pressure	Hepatitis	Stroke
Thyroid Disease	Arthritis	Anemia
Kidney Problems	Cold Sores	HIV/AIDS
Cancer/Chemotherapy	Radiation	TMJ
Stomach Ulcer	Osteoporosis	Blood Thinners

Any other disease, condition, or problem not listed above?

_____

<u>Women</u>: Pregnant or possibly pregnant? Y/N **Nursing**?: Y/N

Signature: _____ **Date**: _____