PATIENT MEDICAL HISTORY FORM

Name ______________________________ Date____________________

Address____
Cell ____________
Phone (home) ____________________ (Work)________________
Birthdate ______________ Sex ______ Height ______ Weight_____
Marital Status _______ Occupation _________ S.S.# ______________
Closest Relative ____________________ Phone _______________
If you are completing this form for another person, what is your relationship to that person?____

In the following questions, circle yes or no, whichever applies. Answers are for our records only and will be kept confidential.

1. Are you in good health? . . . . YES NO
2. Have you ever had rheumatic fever, heart mumur or congenital Heart Disease? . . . . YES NO
3. Has there been a change in your general health within the past Year? . . . . YES NO
4. Date of my last physical examination ________________
5. Are you now under the care of a Physician? . . . . YES NO
   If so, what is the treatment for?________________
6. Name, address and phone of your physician
   ____
   ____
   ____
7. Have you ever had an operation or serious illness? . . . . YES NO
   If so, explain?________________________________
8. Do you, at the present time, have any artificial joints, rods or Screws placed? . . . . YES NO
9. Are you taking any medication or drugs (either prescription or Non-prescription)? If so, what? ____________________ YES NO
10. Have you ever had an allergic or adverse reaction to any Drug or medication? . . . . YES NO
   If so, what? ________________________________
11. Have you taken any presciption medications in the past that you Are no longer taking? . . . . YES NO
   If so, what?__________________________________
12. Have you ever had abnormal bleeding associated with previous Extractions, surgery, or trauma? . . . . YES NO
   If so, explain?________________________________
13. Do you ever have spontaneous bleeding from the nose, mouth, Ears, joints, intestine, stomach, vagina, or urinary tract? . . . . . YES NO
   If so, explain ________________________________
14. Do any family members have a bleeding problem? . . . . YES NO
   If so, explain ________________________________
15. Do you have chest pain upon exertion?. . . . . YES NO

16. Are you short of breath after mild exercise? .... YES NO
17. Do your ankles swell? .... YES NO
18. Do you require extra pillows when you sleep? .... YES NO
19. Do you have to urinate more than 6 times a day? .... YES NO
20. Are you thirsty much of the time? .... YES NO
21. Does your mouth frequently become dry? .... YES NO
22. Do any members of your family have diabetes? .... YES NO
    If so, explain ?______________________________
23. Do you smoke, or use smokeless tobacco?
    If so, how much? ____________________________ YES NO
24. Do you consume alcohol? If so, how much? _______________ YES NO
25. Please circle any of the following which you have had or have at present:

Heart Disease/Attack	Asthma	Bruise easily
Angina Pectoris	Emphysema	Epilepsy or Seizures
Artificial Heart Valves	Chronic Cough	Fainting or Dizzy Spells
Heart Pacemaker	Tuberculosis	Hemophilia
Heart Surgery	Hay Fever	Liver Disease
High Blood Pressure	Sinus Problems	Yellow Jaundice
Low Blood Pressure	Tumors	Hepatitis
Stroke	Thyroid Disease	Mononucleosis
Kidney Problems	Arthritis	Venereal Disease
Anemia	Cold Sores	Aids
Diabetes (Mellitus or Insipidus)	Mouth Ulcers	Aids Related Complex (ARC)
Chemotherapy	Pain in Jaw Joint	Stomach Ulcers
Radiation Therapy	Alcohol/Drug Abuse	

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WOMEN

26. Are you pregnant at this time? .... YES NO
27. Are you nursing at this time? .... YES NO
28. Are you taking birth control medication at this time? .... YES NO

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29. Do you have any disease, condition or problem not listed above that you
    think we should know about? .... YES NO
    If so, explain?______________________________

To the best of my knowledge, all of the preceding answers are correct. If I have a change in my health, or any medication, I will inform the doctor at the next appointment.

____

Signature of Patient and Date

____

Signature of Doctor and Date

Reviewed Medications Date By

____

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