

MEDICAL HISTORY

To be completed by patient – PLEASE PRINT

What is your primary complaint today / What is the reason for your visit? _____

Have you ever had or do you currently have any of the following:

- High Blood Pressure Yes / No
Heart Disease Yes / No Stroke ___ Bypass ___ Stent ___ Other: _____
Diabetes – Self Yes / No List relatives with _____
Ulcer Yes / No Is the condition healed? _____
Bleeding ulcer? _____
Pneumonia Yes / No Year? _____
Hepatitis Yes / No List type: _____
Asthma Yes / No List treatment: _____
Cancer Yes / No List type: _____
Tuberculosis Yes / No Current/Active ___ Not active ___
Thyroid Condition Yes / No
High Cholesterol Yes / No
Other: _____

Please list all current MEDICINES (including over the counter medications). If possible, list the name, dose and name of prescribing doctor, if applicable.

No medications at this time

Medication list attached

- 1) _____ 6) _____
2) _____ 7) _____
3) _____ 8) _____
4) _____ 9) _____
5) _____ 10) _____

Do you have any medication ALLERGIES? List all, including over the counter medications).

None

- 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Please list all SURGERIES that you have had in your lifetime.

None

- 1) _____ Year _____
2) _____ Year _____
3) _____ Year _____
4) _____ Year _____

Do you use tobacco? Yes / No - Smoke / Chew: How much _____ How often _____

If you have quit smoking, How long ago _____ How much you smoked _____

Caffeine intake, including soda, tea, coffee: Cups per Day _____ Week _____ Month _____

Alcohol intake: please circle daily / weekly / monthly / rarely / never

Do you have dentures? Yes / No please circle Full / partial / uppers / lowers

Are you currently undergoing any dental treatment? _____

Patient Name (please print) _____ Date: _____