Patient Medical History

If female, please answer the following:

Y	N	
☐	☐	Are you pregnant?
☐	☐	Are you nursing?
☐	☐	Are you taking birth control pills?

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?

Y	N	**Conditions**
☐	☐	Abnormal Bleeding
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Bruise Easily
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Coumadin
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	Glaucoma

Y	N	**Conditions**
☐	☐	HIV + AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Pace Maker
☐	☐	Mitral Valve Proplapse
☐	☐	Pain in Jaw Joints
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiating Therapy
☐	☐	Recent Surgeries
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Stroke

Y	N	**Conditions**
☐	☐	Tuberculosis
☐	☐	Thyroid Problems
☐	☐	Ulcers

Y	N	**Allergies**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

Medications

Y	N	
☐	☐	Is there any disease, condition or problem that you think this office should know about that is not covered above? If yes, please describe below.