2016 Patient Medical History Form

Name: ______________________________ Date: ______________________________
Occupation: ______________________________ Birthdate: ______________________________
Reason for today's visit: ____
Are you allergic to any medications? ❑ Yes ❑ No
If yes, please list: ____
Have you ever had a reaction to dental or local anesthesia (novocaine)?
❑ Yes ❑ No If yes, describe the reaction: ____
Do you take antibiotics before you go to the dentist?
❑ Yes ❑ No If yes, why: ____
Do you have a pacemaker or implanted defibrillator? ❑ Yes ❑ No
If female are you pregnant or nursing? ❑ Yes ❑ No
Do you smoke? ❑ Yes ❑ No Do you drink alcohol? ❑ Yes ❑ No How much? ______________
List all medications and topicals that you use regularly, including prescriptions, over the counter meds, Vitamins and herbal supplements: ____
____

Do you now have, or have you ever had the following diseases or conditions? (Yes or no)

Skin Cancer	❑ Yes	❑ No	If yes, list: ______________
Family history of skin cancer	❑ Yes	❑ No	If yes, list: ______________
Specific skin conditions	❑ Yes	❑ No	If yes, list: ______________
Cold sores	❑ Yes	❑ No	If yes, list: ______________

Do you have any of these health conditions:

High Blood Pressure	❑ Yes	❑ No	Emphysema	❑ Yes	❑ No
History of Heart Attack	❑ Yes	❑ No	Asthma	❑ Yes	❑ No
Coronary Artery Disease	❑ Yes	❑ No	Chronic Cough	❑ Yes	❑ No
Undiagnosed Chest Pain	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No	Wheezing	❑ Yes	❑ No
Irregular Heartbeat	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Artificial Heart Valve	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No
Peripheral Vascular Disease	❑ Yes	❑ No	Thyroid Disease	❑ Yes	❑ No
Congestive Heart Failure	❑ Yes	❑ No	Seasonal Allergies	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Bleeding/Clotting Disorder	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No	Varicose Veins	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Gastrointestinal Disease	❑ Yes	❑ No
Epilepsy/Seizure	❑ Yes	❑ No	Liver Disease/Hepatitis	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Artificial Joints	❑ Yes	❑ No
Mental Illness	❑ Yes	❑ No	HIV	❑ Yes	❑ No

List any other conditions/major surgeries:
____
Completed by: ❑ Patient ❑ Family Member (Read and Reviewed with the Patient)
Patient Signature: ______________________________ Date: ______________________________
Provider Signature: ______________________________ Date: ______________________________

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