



## 2018 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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