MEDICAL HISTORY

NAME: _____ DATE: _____

PHYSICIANS OFFICE:_____PHYSICIAN:_____

ALLERGIES:_____NONE_____

LATEX ALLERGY? Y N PREMED REQUIRED? Y N

CURRENT MEDICATIONS: (Please list all prescriptions, supplements, and over the counter medications)

_____

_____See List_____

PLEASE CHECK ALL THAT APPLY (Past and Current)

_____ Under physicians care
_____ Hospitalized/Operation last 5 yrs
_____ Women: Pregnant (Current)
_____ Women: Nursing (Current)
_____ Women: Oral Contraceptive
_____ Heart trouble/disease
_____ **Artificial Joints**
_____ Heart murmur
_____ Rheumatic fever
_____ Mitral valve prolapse
_____ Heart Surgery
_____ Artificial heart valves
_____ Pacemaker
_____ Indwelling defibrillator
_____ **High blood pressure**
BP: /
_____ Stroke
_____ Bleeding problems
_____ Hemophilia
_____ Anemia
_____ Leukemia
_____ Lung Disease
_____ Shortness of Breath
_____ Glaucoma
_____ Thyroid Disease

_____ **Asthma**
_____ Sleep Apnea
_____ Tuberculosis
_____ Sinus Trouble
_____ History of Cancer (SELF)
_____ Radiation to Head/Neck
_____ Chemotherapy
_____ Eating Disorder
_____ Stomach Reflux or Ulcer
_____ Immunological Disease
_____ Sjogren's Disease
_____ Fibromyalgia
_____ Other autoimmune diseases
_____ Arthritis or Joint Disorder
_____ Diabetes: Type_____ Controlled? Y N
_____ Frequent Headaches
_____ Depression: Diagnosed? Y N
_____ Epilepsy/ Seizures
_____ Cerebral Palsy
_____ Fainting/Dizziness
_____ Venereal Disease
_____ AIDS/HIV (antibiotics or positive)
_____ Alcohol or chemical dependency
_____ Hepatitis
_____ HPV
_____ HPV Vaccine

Smoker: Y N # of years:_____ Attempts to quit:_____

Smokeless Tobacco: Y N

Any Other Medical Concerns We Should Be Aware Of: _____

Any Chief Dental Concerns: _____

SIGNATURE: _____