

PATIENT NAME: \_\_\_\_\_

### MEDICAL HEALTH HISTORY:

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain .....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath .....	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever .....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve .....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising .....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds .....	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding .....	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia) .....	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion? .....	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever .....	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes .....	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss .....	<input type="checkbox"/>	<input type="checkbox"/>
Special diet .....	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/Diarrhea .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Joint Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain .....	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement .....	<input type="checkbox"/>	<input type="checkbox"/>
(e.g., total hip, pins, or implants) .....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells, Seizures, or Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke(s) .....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or swollen glands .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Premedications required by physician</b> .....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor .....	<input type="checkbox"/>	<input type="checkbox"/>

Are you allergic, or have you reacted adversely, to any of the following?	Yes	No
Local anesthetics ("Novocaine")	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, demerol, or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Notes: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

	Yes	No
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than 6 times a day .....	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty or mouth is dry much of the time .....	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other respiratory disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? .....	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Do you smoke/use tobacco? .....	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Hepatitis, jaundice, or liver trouble .....	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD .....	<input type="checkbox"/>	<input type="checkbox"/>
HIV-positive/AIDS .....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses? .....	<input type="checkbox"/>	<input type="checkbox"/>
History of head injury? .....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or other neurological disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed previously that you feel we should know about?		
If so, please describe: _____		
Please list current medications: _____		
_____		
_____		
_____		

During the past 12 months, have you taken any of the following?	Yes	No
Anticoagulants (e.g., Coumadin)	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase, or similar drug	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids)	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>
_____		

Women	Yes	No
Are you taking contraceptives or other hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date: _____		
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause?	<input type="checkbox"/>	<input type="checkbox"/>

Notes: \_\_\_\_\_

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