PLEASE ANSWER ALL QUESTIONS COMPLETELY (Numbers 1-13)

PATIENT MEDICAL HEALTH RECORD

DATE:_____

1) Name and address of physician_____
2) Have you been under a physician's care during the past 2 years?_____For_____
3) Have you been treated in a hospital in the past 2 years?_____For_____
4) Have you ever had major surgery?_____For_____
5) Have you ever had a major accident?_____Year_____What kind_____
6) If female: Are you taking hormones or birth control? _____Are you pregnant or nusing?_____
7) Have you ever had a blood test for hepatitis?_____Were you vaccinated for hepatitis?_____
8) Have you had cankers or cold sores on your lips, tongue, gums or body?_____
9) Are you now taking or have you taken any prescription drugs during the past year?_____For?_____
   Please list medication (s)_____
10) Are you allergic to:

yes	no		yes	no	
☐	☐	Penicillin	☐	☐	Local Anesthetics
☐	☐	Codeine	☐	☐	Other Allergies_____

11) Height_____Weight_____
12) Have you had or do you have:

	Yes	No			
AIDS……	☐		Glaucoma…….	☐	☐
☐			Heart disease……...	☐	☐
Abnormal blood pressure……	☐		Heart murmur……	☐	☐
☐			Hepatitis…….	☐	☐
Allergies…….	☐	☐	Herpes…….....	☐	☐
Anemia……...	☐		Jaundice……..	☐	☐
☐			Kidney Disease…….....	☐	☐
Angina…….	☐		Liver Disease……	☐	☐
☐			Organ Transplant……	☐	☐
Arthritis…….	☐		Pacemaker……	☐	☐
☐			Polio……..	☐	☐
Artificial heart valves……..	☐		Prolonged Bleeding……	☐	☐
☐			Prolonged Cough……	☐	☐
Artificial joints……..	☐	☐	Psychiatric Treatment…….....	☐	☐
Asthma……..	☐	☐	Radiation Therapy…….	☐	☐
Cancer……	☐	☐	Rheumatic Fever……	☐	☐
Chemotherapy…….	☐	☐	Sickle Cell Anemia……	☐	☐
Congenital heart lesions…….	☐	☐	Stroke……..	☐	☐
Diabetes……	☐	☐	Taken Phen Phen or Redux..	☐	☐
Drug Dependency……...	☐	☐	Smoke/ Chewing Tobacco…	☐	☐
Epilepsy……	☐	☐	Consume Alcohol……..	☐	☐
Fainting…….	☐	☐	Previous Negative dental visit	☐	☐
			HIV Positive……	☐	☐

13) Have you any disease, condition, or problem not previously listed? _____
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