MEDICAL HISTORY FORM

Elite Oral Surgery of Wellington

12157 W Forest Hill Blvd, Suite 115, Wellington, FL 33414
Phone: (561) 790-0206 | Fax: (561) 795-5445

PATIENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: M / F

MEDICAL CONDITIONS

Please check all that apply:

__ Heart Disease __ High Blood Pressure __ Diabetes __ Asthma
__ Kidney Disease __ Liver Disease __ Cancer __ HIV/AIDS
__ Bleeding Disorder __ Seizures __ Stroke __ Arthritis
__ Allergies __ Thyroid Problems __ Hepatitis __ Anemia

CURRENT MEDICATIONS

Please list all medications, vitamins, and supplements you are currently taking:

_____
_____
_____

ALLERGIES

List any allergies to medications, latex, or other substances:

_____

Patient Signature: _____ Date: _____