Patient Medical History

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Today's Date _____–_____–_____
Month Day Year

I. Patient Information

Name _____ ____ _____
First MI Last

Occupation _____

Are you allergic to any medications? ☐ Yes: _____ ☐ No

_____

Have you ever had dental anesthesia (Novocaine or Xylocaine)? ☐ Yes ☐ Yes, and I had a bad reaction ☐ No

Current prescription medications: _____

Current over-the-counter products: _____
including vitamins, supplements, etc.

II. Diseases and Conditions

Do you have now, or have you ever had diseases or conditions of: *(check **Yes** or **No**)*

Lungs	**Yes**	**No**
Emphysema	☐	☐
Asthma	☐	☐
Cardiovascular		
High blood pressure	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Irregular heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker/Defibrillator	☐	☐
Stents or Angioplasty	☐	☐

Gastrointestinal	**Yes**	**No**
Hepatitis A, B, or C	☐	☐
Yeast infection when taking antibiotics	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
Arthritis	☐	☐
Artificial joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐
Depression, ongoing emotional problems	☐	☐
Other Medical Problems		
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐

Malignancy

Type: _____ Date Diagnosed: _____–_____–_____
Month Day Year

Treatment: _____

Continued Care: _____

List any other diseases or conditions: _____

Surgical procedures in the last 12 months: _____

III. Social History

Do you drink alcohol? ☐ Yes, about _____ drinks daily ☐ No

Do you smoke? ☐ Yes ☐ No, not currently ☐ Never

Do you have, or have you been exposed to, HIV/AIDS? ☐ Yes ☐ No

Have you ever used IV drugs? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes, due: _____–_____–_____ ☐ No
Month Day Year

Patient Signature _____ Date _____–_____–_____
Month Day Year

Reviewed by _____ Date _____–_____–_____
Month Day Year