PATIENT MEDICAL HISTORY

PATIENT: _____ **DATE:** ____/____/____

MEDICATION ALLERGIES: ☐ NONE ☐ YES (PLEASE LIST)_____
_____

Are you sensitive to: ☐ Foods ☐ Environment (dust/pollen/pets) ☐ Bandages ☐ Topical Neosporin
Have you ever had "Numbing Medicine" (Novacaine, Lidocaine)? ☐ No ☐ Yes **Any Reaction?** ☐ No ☐ Yes
Current Medications (including over-the-counter remedies, vitamins, herbals) 1)_____

2) _____ **3)** _____ **4)** _____

5) _____ **6)** _____ **7)** _____

Are you required to take antibiotics prior to dental or surgical procedures? ☐ No ☐ Yes
Do you have or have you ever had the following Conditions? Denote a family condition checking where indicated:

LUNGS:	NO	YES	FAMILY HISTORY	OTHER SYSTEMIC:	NO	YES	FAMILY HISTORY
Bronchitis				Diabetes			
Emphysema				Thyroid			
Asthma				Kidney			
Chronic Cough				Dialysis			
Morning Cough				Excessive Urination			
Shortness of Breath				Burning while Urinating			
Wheezing				Gastrointestinal			
Allergies				Nausea, vomiting			
				Diarrhea			
CARDIOVASCULAR:				Arthritis			
High Blood Pressure				Convulsions/Seizures			
Chest Pain				Fainting			
Heart Attack				Polycystic ovaries			
Heart Murmur				Yeast Infections			
Irregular heartbeat				INFECTIOUS DISEASE:			
Phlebitis				Hepatitis			
Blood clots				HIV			
Pacemaker				MRSA			
HEMATOLOGY ONCOLOGY:				Syphilis			
Bleeding disorders							
Cancer							

if yes, what type of cancer _____
SKIN: Have you ever had Skin Cancer? ☐ No ☐ Yes **What type?** _____
Has anyone in your family had Skin Cancer? ☐ No ☐ Yes **What type?** _____
Do you have a history of any specific skin diseases? ☐ No ☐ Yes **What type?** _____
Do you have problems with wounds healing? ☐ No ☐ Yes
Do you develop large scars (Keloids) after surgery? ☐ No ☐ Yes
List any other diseases or conditions:_____
List any Surgical Procedures in the last six months _____
(Women) Are you currently pregnant? ☐ No ☐ Yes **Due date?** _____

SOCIAL HISTORY:
Do you drink alcohol? ☐ No ☐ Yes **How many drinks per day?** _____
Do you use recreational drugs? ☐ No ☐ Yes **What kind?** _____ **How often?** _____
Do you smoke? ☐ No ☐ Yes **How often?** _____ **How much?** _____
What is your occupation? _____ **Hobbies?** _____
Completed by ☐ Patient ☐ Parent/Guardian ☐ Medical Assistant _____ **(initials)**

_____ _____
Patient **Date** **Provider** **Date**