Medical History

Please fill in the spaces below as accurately as possible, For your safety, it is necessary as part of any complete examination to know about your general health. The material will, of course be held confidential .

Name_____ Date of Birth_____

1. Are you under a physicians care? Y or N Family Physician:_____
2. What is your sensitivity to medications? I need ( )More ( )Less ( ) Same dose of medication compared to others.
3. Are you allergic to any of the following? Codeine ( ) Novocaine( ) Penicillin () Other:_____
4. Height_____ Weight_____
5. Have you had any serious illness or been hospitalized in the last 5years? Y or N
   Describe_____
6. Have you ever been given anesthesia before (put to sleep) ? Y or N
   What type of sedation and were there any complications?_____
7. (Women) Are you pregnant? Y or N Are you taking birth control pills? Y or N
8. Have you ever had or do you have: (Please check)
9. How often do you brush your teeth?_____ How often do you floss your teeth?_____
10. What type of mouthwash do you use? _____

Problems with dental treatment	( )	Problems with anesthetics	( )
Clench of Grind your teeth	( )	Gag easily	( )
Clicking or pain in the jaw joint	( )	Snoring Problem	( )
Headaches	( )	Jewelry or metal sensitivity	( )
Difficulty swallowing	( )		

Conditions

Heart/Circulatory

Heart trouble ( )
Heart Murmur ( )
Heart attack ( )
Angina ( )
Chest Pains ( )
Heart Stent ( )
Heart Valve replacement ( )
Heart transplant ( )
Congenital Heart Abnormalities ( )
Heart Arrhythmias (Atrial Fibrillation, etc.) ( )
Shortness of Breath ( )
High Blood Pressure ( )
Low Blood Pressure ( )
High Cholesterol ( )

Brain

Stroke ( )
TIA ( )
Aneurysm ( )
Seizures/Epilepsy ( )
Vertigo ( )
Dementia ( )
Alzheimer's ( )
Neuralgia ( )
Anxiety ( )
Depression ( )
Psychosis (Bipolar, OCD, etc.) ( )

Blood disorders

Anemia ( )
Bleeding Problems ( )
Blood clotting Problems ( )
Sickle Cell Disease ( )
DVT ( )
Embolism ( )

Organ systems

Hepatitis ( )
Diabetes ( )
Kidney disease ( )
Thyroid problem ( )
Cancer ( )
Lung problems ( )
Persistent Cough ( )
Sleep Apnea ( )
Asthma ( )
COPD ( )
Emphysema ( )
Sinus Troubles ( )
Environmental allergies ( )
Food allergies ( )
Allergy to medication ( )
Stomach ulcers ( )
GERD/ Gastric Reflux Disease ( )
Bulimia/Anorexia ( )
Intestinal disorder (Crohn's disease, etc.) ( )

Musculoskeletal

Arthritis ( )
Joint replacement ( )
Fibromyalgia ( )
Other Muscular-Skeletal diseases ( )

Infectious Disease

Tuberculosis ( )
HIV + ( )
Venereal Disease ( )
Herpes ( )
Hepatitis A, B, C, D, ( )

Other

Using any psychoactive substances/recreational drugs Y or N
Alcohol use: daily _____, weekly_____, monthly_____
Smoking : how many years _____, how many per day _____
Chewing tobacco ( )
Smokeless tobacco ( )
Electronic Cigarettes ( )
Physical Disability ( ) _____
Mental Disability ( ) _____

Medications :

Vitamins:

Supplements:

Herbal supplements:

_____ _____

PRINT and SIGNATURE of patient or guardian DATE