



Patient Medical History

Patient's Name: _____ Age: _____ Height: _____ Weight: _____

Primary Medical Doctor: _____ Doctor's Phone number: _____

Please answer all questions. Please circle Yes or No and explain where necessary.

Yes / No Do you have any medical conditions?

Please list all past or present conditions. _____

Yes / No Have you ever been hospitalized or had a major illness or operation? _____

Yes / No Have you ever had a serious head or neck injury? _____

Yes / No Do you use tobacco products? _____

Yes / No Do you take any anticoagulants or blood thinners? _____

Yes / No Do you need to take antibiotics before Dental Appointments? _____

Yes / No Personal or family history of problems with anesthesia including malignant hyperthermia (MH)?

Women only. Are you:

Pregnant/Trying to get pregnant? Yes / No Taking oral contraceptives? Yes / No Nursing? Yes / No

Please list all ALLERGIES: _____

Yes / No Latex Allergy? _____

Do you have, or have you ever had, any of the following? Please (√) all that apply.

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cortisone/Steroid Medicine	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Stroke
<input type="checkbox"/> Angina	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Fainting spells/Dizziness	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Gastric Reflux/GERD	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Mitral/Heart Valve Disease	<input type="checkbox"/> Other-please list
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pain in Jaw joints	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Psychiatric Care	_____
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Radiation Treatments	_____
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Renal Dialysis	_____

Please List all current medications, including over the counter medication and supplements.

"I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. I certify that the information provided here is accurate and complete and that I will ask questions of my doctor and assisting staff to clarify any items I do not understand."

Patient/Guardian Signature: _____ Date: _____