

Medical History Form

Patient's Name _____ Date of Birth _____ Dentist _____

Chart No _____ Incoming BP _____ Pulse _____

Please Check **ONLY** the Box for any condition you have had in the past or have now

Cardiovascular	Box	Add Comments	Respiratory	Box	Add Comments
Congestive Heart Failure			Hayfever		
Heart Attack/Disease		When _____	Sinus Trouble		
Angina or Chest Pain		Type _____	Allergy/Hives		
Heart Surgery		When _____	Asthma		Inhaler use _____
Hypertension		How Long _____	Emphysema		O2 Therapy _____
Infective Endocarditis		When _____	Bronchitis		
Congenital Heart Defect		Surgery _____	Tuberculosis		Diagnosed _____
Prosthetic Heart Valve			Breathing Difficulties		When _____
Arrhythmias			Dermatologic		
Pacemaker/Defibrillator			Allergy to Latex		
Heart Transplant		When _____	Allergy to Food or Drugs		Types(s) _____
Other Heart Problems			Skin Rash		Location _____
Blood Thinners		Type _____	Fever Blisters		Frequency _____
Aneurysm			Canker Sores		
Shortness of Breath			Endocrine		
Swollen Ankles			Diabetes		Type _____
Sleep Disorder			Thyroid Disease		Hyper ____ Hypo ____
Hematologic			Steroid Use		
Blood Transfusion		When _____	Genitourinary		
Anemia			Kidney Problems		
Hemophilia			Dialysis		Schedule _____
Leukemia		When _____	Sexually Transmitted Disease		Type _____
Sickle Cell Disease		Type _____	Musculoskeletal		
Bleeding Tendencies			Arthritis		Type _____
Neurologic			Joint Replacement		Location _____
Glaucoma			Bone Disorders		
Hearing Loss			Muscle Disorders		
Severe Headaches			Other		
Fainting Spells			Prostate Problems (Male)		
Stroke/CVA		When _____	HIV Positive		
Seizures/Epilepsy		Hospitalized _____	IV Drug Addiction		
Psychiatric Treatment			Drug Addiction		Type _____
Paralysis			Do you Drink Alcohol		How Often _____
Gastrointestinal			Tumor or Cancer		
Stomach Ulcers			Cobalt Treatment		Location _____
Gastritis/Colitis			Chemotherapy		
Hepatitis			Organ Transplant		Type _____
Liver Disease			Tobacco Use		How Much _____
Yellow Jaundice			Unexplained Weight loss or Gain		
Cirrhosis			Other Conditions Not Listed		
Eating Disorders			Reaction to General Anesthesia		Type _____
Diet Suppressants			Specific Drug Allergies		
Women Only			Local Anesthetics		Type _____
Currently Pregnant		Trimester _____	Antibiotics		Type _____
Currently Breast Feeding			Codiene/Narcotics		Type _____
Use of Oral Contraceptives			Aspirin/NSAIDS		Type _____

PLEASE COMPLETE OTHER SIDE

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