MEDICAL HEALTH HISTORY

Do you have, or have you had any of the following?

YES NO

Heart Problems

☐ ☐ Chest Pain/Angina
☐ ☐ Shortness of breath
☐ ☐ Blood pressure problems
☐ ☐ Heart murmur
☐ ☐ Heart valve problems
☐ ☐ Artificial heart valve
☐ ☐ Heart Attack or Stroke (circle)
☐ ☐ Rheumatic Fever
☐ ☐ Pacemaker

Blood Problems

☐ ☐ Easy bruising
☐ ☐ Frequent nosebleeds
☐ ☐ Abnormal bleeding
☐ ☐ Blood disease (anemia)
☐ ☐ Ever require a blood transfusion

Allergy Problems

☐ ☐ Hay fever
☐ ☐ Sinus Problems
☐ ☐ Skin rashes
☐ ☐ Taking allergy medication
☐ ☐ Asthma

Intestinal Problem

☐ ☐ Ulcers
☐ ☐ Weight gain or loss
☐ ☐ Special diet
☐ ☐ Constipation/Diarrhea
☐ ☐ Kidney or bladder problem

Bone or Joint Conditions/Therapies

☐ ☐ Arthritis/Rheumatism
☐ ☐ Back or neck pain
☐ ☐ Joint replacement (e.g., total hip, pins, or implants)
If so, location & placement date: __________________
____
☐ ☐ **Premedication** required by physician
☐ ☐ Fainting spells, seizures, or Epilepsy
☐ ☐ Neurological disease
☐ ☐ Thyroid problem (hyper/hypo)
☐ ☐ Persistent cough or swollen glands
☐ ☐ Cancer/tumor
☐ ☐ Radiation/Chemotherapy
If so, date of treatment: __________________________

Are you allergic to, or have you reacted adversely, to any of the following?

YES NO

☐ ☐ Local Anesthetic (“Novocain”)
☐ ☐ Penicillin or other antibiotics
☐ ☐ Sulfa Drugs
☐ ☐ Barbiturates, sedatives, or sleeping pills
☐ ☐ Aspirin, Acetaminophen, or Ibuprofen
☐ ☐ Codeine, Demerol, or other narcotics
☐ ☐ Reaction to metals
☐ ☐ Latex or rubber dam

Other: ____

YES NO

Diabetes

☐ ☐ Thirsty or mouth is dry much of the time
☐ ☐ Diabetes or Family history of diabetes (circle one)

Other Health Conditions or Therapies

☐ ☐ Tuberculosis or other respiratory disease
☐ ☐ Do you drink alcohol?
If so, how much? ____________________________
☐ ☐ Do you smoke?
If so, how much? ____________________________
☐ ☐ Emphysema/Lung problems
☐ ☐ Hepatitis, jaundice or liver trouble
☐ ☐ Herpes or other STD
☐ ☐ Cold sores
☐ ☐ HIV-positive/AIDS
☐ ☐ Psychiatric treatment
☐ ☐ Glaucoma
☐ ☐ Do you wear contact lenses?
☐ ☐ History of head injury?
☐ ☐ History of alcohol or drug abuse?

Do you have any disease, condition, or problem not listed previously that you feel we should know about? (Including recent surgeries)

If so, please describe: ____
____
____

During the last 12 months, have you taken any of the following?

YES NO

☐ ☐ Antibiotics or sulfa drugs?
☐ ☐ Anticoagulants (e.g., Coumadin)
☐ ☐ High blood pressure medicine
☐ ☐ Tranquilizers
☐ ☐ Insulin, Orinase, or similar drug
☐ ☐ Aspirin
☐ ☐ Digitalis or drugs for heart trouble
☐ ☐ Cortisone (steroids)
☐ ☐ Natural remedies
☐ ☐ Non-prescription drug/Supplements
☐ ☐ Bisphosphonates (used for osteoporosis)

Please list any additional medications: __________________________
____
____
____
____

Women

☐ ☐ Are you taking contraceptives or other hormones?
☐ ☐ Are you pregnant?
If so, expected delivery date: _____________________
☐ ☐ Have you reached menopause?

Notes:____
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____
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Patient/Parent Signature **Date**

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