Patient Medical History

Patient Name_____Date of Birth_____Today's Date_____

Primary Care Physician (M.D.) _____Office Phone_____

1. **Please LIST all current medications.**
   _____
   _____
   _____

2. **Are you a SMOKER?** ☐Yes (#Packs/day?_____) ☐No
3. **Do you use chewing tobacco?** ☐Yes ☐No

4. **Are you ALLERGIC to or have you had any reactions to the following?**
   - Local anesthetics with EPINEPHRINE…….…….. ☐Yes ☐No
   - Penicillin or Amoxicillin……..…… ☐Yes ☐No
   - Tylenol……..…….. ☐Yes ☐No
   - Ibuprofen……..……. ☐Yes ☐No
   - Aspirin……..……..... ☐Yes ☐No
   - Hydrocodone……..……..... ☐Yes ☐No
   - Any Metals (eg. Nickel, mercury, etc.)…… ☐Yes ☐No
   - Latex…….……. ☐Yes ☐No
   - Other Allergies (list)_____

5. **Any significant events related to your health in the past?**
   - Heart Attack ….…….. ☐Yes (When?_____) ☐No
   - Stroke …….…… ☐Yes (When?_____) ☐No
   - Joint Replacement ……. ☐Yes (When?_____) ☐No
   - Tuberculosis……..……. ☐Yes (When?_____) ☐No
   - Asthma …….…….....☐Yes (Last Attack?_____) ☐No
   - Hepatitis …….……☐Yes (Type?_____) ☐No
   - Cancer ……..……☐Yes (When?_____ Type?_____) ☐No

6. **Do you have or have you ever had any of the following**?

High Blood Pressure……..…...	☐Yes ☐No	Diabetes…….……..	☐Yes ☐No
Heart Disease…….…….	☐Yes ☐No	Kidney Dysfunction…….....	☐Yes ☐No
Angina…….……	☐Yes ☐No	Liver Dysfunction……..	☐Yes ☐No
Cardiac Pacemaker…….…….	☐Yes ☐No	AIDS or HIV Infection……	☐Yes ☐No
Sleep Apnea…….……	☐Yes ☐No	Thyroid Dysfunction...……	☐Yes ☐No
Psychiatric Care…….……..	☐Yes ☐No	Glaucoma…….…….	☐Yes ☐No
Fainting/Syncope…..…..…..…	☐Yes ☐No	Arthritis……	☐Yes ☐No
Epilepsy/Seizures……	☐Yes ☐No	Gastric Reflux.…….……....	☐Yes ☐No
Emphysema/COPD…..……..	☐Yes ☐No	Anemia…….……	☐Yes ☐No
High Cholesterol……	☐Yes ☐No	Frequent Headaches ……	☐Yes ☐No

Other_____

7. **Women Only**:
   - a. Are you pregnant or think you may be pregnant? …….…… ☐Yes ☐No
   - b. Are you nursing? ……..…….. ☐Yes ☐No
   - c..Are you taking birth control pills? ..... ☐Yes ☐No