

Patient Medical History

Patient: _____ Date: _____

Reason for visit: _____

Please list any medications you are allergic to: _____

Have you ever had a negative reaction to novocaine? () yes () no

List all medications you are currently taking (list any over the counter, herbals, vitamins, and prescriptions): _____

Do you now or have you ever suffered from any of the conditions listed below (check yes or no):

Lungs:

- Bronchitis () yes () no
- Emphysema () yes () no
- Asthma () yes () no
- Chronic Cough () yes () no
- Morning Cough () yes () no
- Shortness of Breath () yes () no
- Wheezing () yes () no

Other Systemic:

- Diabetes () yes () no
- Excessive Thirst or Hunger () yes () no
- Thyroid () yes () no
- Kidney () yes () no
- Bladder () yes () no
- Bladder Frequency / Burning () yes () no
- Gastrointestinal () yes () no
- Stomach Disorder () yes () no
- Nausea () yes () no
- Liver Disease () yes () no
- Yeast Infection () yes () no
- Arthritis () yes () no
- Artificial Joints () yes () no
- Convulsions or Seizures () yes () no
- Fainting () yes () no

Cardiovascular:

- High Blood Pressure () yes () no
- Chest Pain () yes () no
- Heart Attack () yes () no
- Heart Murmur () yes () no
- Irregular Heart Beat () yes () no
- Phlebitis () yes () no
- Inflammation of Vein () yes () no
- Blood Clots () yes () no
- Pacemaker () yes () no

If you answered yes to any of the conditions above, please give the date if applicable and list any additional information:

Skin:

When you are exposed to sun do you: () tan () burn () tan/burn

Have you ever had skin cancer? () yes () no If yes, what type? _____

Has anyone in your family had skin cancer? () yes () no If yes, who? _____

Do you now or have you ever had a skin disease? () yes () no If yes, what type? _____

Do you develop skin rashes in reaction to () medications () food () environment

Please list any other diseases or conditions you suffer from: _____

Please list any surgical procedures you have had in the last 6 months: _____

Social History:

Do you drink alcohol? () yes () no If yes, how much? _____ (drinks per day)

Do you use IV drugs? () yes () no If yes, what? _____ How Often _____

Do you smoke? () yes () no If yes, how much? _____ (per day)

Do you have or have you been exposed to HIV (AIDS)? () yes () no

Do you have or have you been exposed to Hepatitis B or C? () yes () no

Please answer the following:

Do you bleed easily? () yes () no What is your occupation / hobbies? _____

Are you pregnant? () yes () no How did you hear about us? _____

Patient Signature: _____

Date: _____