# Medical Health History

***Patient Name*** _____

*Do you have or have you had any of the following? (check all that apply)*

- ☐ Heart Attack or heart problems
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blood pressure problem
- ☐ Heart murmur
- ☐ Heart valve problem
- ☐ Taking heart medication
- ☐ Rheumatic fever
- ☐ Artificial heart valve
- ☐ Pacemaker
- ☐ Blood disease or blood problems
- ☐ Easy bruising
- ☐ Frequent nosebleed/abnormal bleeding
- ☐ Anemia
- ☐ Ever require a blood transfusion?
- ☐ Allergy problems
- ☐ Hay fever
- ☐ Sinus problems
- ☐ Taking allergy medication
- ☐ Asthma
- ☐ Acid reflux (GERD, heartburn)
- ☐ Intestinal problems
- ☐ Ulcers
- ☐ Weight gain or loss
- ☐ Special diet
- ☐ Constipation/diarrhea
- ☐ Kidney or bladder problems
- ☐ Fainting spells, seizures or epilepsy
- ☐ Stroke(s)
- ☐ Frequent or severe headaches
- ☐ Neurologic disorder
- ☐ Thyroid problems
- ☐ Persistent cough or swollen glands
- ☐ Pre-medications required by physician
- ☐ Cancer/tumor
- ☐ Diabetes or Family history of diabetes
- ☐ Urinate more than six times a day
- ☐ Thirsty or mouth is dry much of the time
- ☐ Tuberculosis or other respiratory disease
- ☐ Bone or joint problems
- ☐ Arthritis
- ☐ Back or neck pain
- ☐ Joint replacement (e.g. hip, pins, implants)
- ☐ Other disease, condition or problem not listed above:

☐ Drink alcohol or use recreational drugs?
If so, how much? _____

- ☐ History of alcohol or drug abuse
- ☐ Hepatitis, jaundice or liver trouble
- ☐ Herpes or other STD
- ☐ HIV positive/AIDS
- ☐ Glaucoma
- ☐ Do you wear contact lenses?
- ☐ Head injury
- ☐ Epilepsy or other neurologic disease

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

- ☐ Antibiotics or sulfa drugs
- ☐ Chemotherapy
- ☐ Anticoagulants (e.g. Coumadin, Plavix)
- ☐ High blood pressure medicine
- ☐ Tranquilizers
- ☐ Insulin, Tolbutamide or similar drug
- ☐ Aspirin
- ☐ Digitalis or drugs for heart trouble
- ☐ Nitroglycerin
- ☐ Cortisone (steroids)
- ☐ Bisphosphonates (Boniva, Fosamax)
- ☐ Nonprescription drug/supplements
- ☐ Natural remedies
- ☐ Other_____

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

- ☐ Local anesthetics (Novocain)
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives or sleeping pills
- ☐ Aspirin, acetaminophen or ibuprofen
- ☐ Codeine, Demerol or other narcotics
- ☐ Sulfites
- ☐ Latex or rubber dam, Metals
- ☐ Other: _____

What medications are you currently taking?

_____
_____
_____
_____

**Women**

- ☐ Are you taking contraceptives or hormones
- ☐ Are you pregnant?
- ☐ If so, expected delivery date_____?
- ☐ Are you nursing?
- ☐ Have you reached menopause?
- ☐ If so, do you have symptoms?

_____ _____
Patient signature/legally authorized representative and relationship — Date

_____ _____
Printed name if signed on behalf of the patient — Relationship

_____ _____
Doctor Signature — Date