MEDICAL HISTORY - PLEASE ANSWER ALL QUESTIONS

Patient's Name: _____ **Date of Birth:** _____

1. Have you ever suffered from? to?_____

	Yes	No
Heart disease	❒	❒
High blood pressure	❒	❒
Heart Attack	❒	❒
Emphysema	❒	❒
Asthma	❒	❒
Blood Disease	❒	❒
Kidney Disease	❒	❒
Glaucoma	❒	❒
Diabetes	❒	❒
Liver disease/Hepatitis	❒	❒
Cancer	❒	❒
Anemia	❒	❒
Thyroid Disease	❒	❒
Bruise easily	❒	❒
HIV	❒	❒
Facial Trauma	❒	❒
Herpes/cold sores	❒	❒
Skin Infections	❒	❒

2. Do you take any of the following?

Blood pres Meds.	❒	❒
St. John's Wort	❒	❒
Aspirin	❒	❒
Ginkgo	❒	❒
Garlic	❒	❒
Ginseng	❒	❒
Vitamin E	❒	❒
Other	❒	❒

3. Do you take

Aspirin	Yes ❒	No❒
Aleve	Yes❒	No❒
Valtrex	Yes❒	No❒
Acyclovir	Yes❒	No❒

4. What Prescription/over the Counter are you currently Taking?_____

_____

_____

_____

5. What medications are you allergic

_____

6. Do you have any of the following habits?

❒ **Smoking Frequency**_____**Years**_____

❒ **Alcohol Frequency**_____ **Years**_____

❒ **Recreational Drugs Frequency**_____**Years**_____

7. Primary care doctor:_____

Phone #_____ **Last Physical :**_____

8. Have you had a recent: ❒ **Yes** ❒ **No - Normal** ❒ **Abnormal**

Chest x-ray ❒ **Yes** ❒ **No - Normal** ❒ **Abnormal**

Electrocardiogram ❒ **Yes** ❒ **No - Normal** ❒ **Abnormal**

9. Do you have any eye problems? ❒ **Yes** ❒ **No**

Explain: _____

10. Have you ever had any previous surgery including plastic surgery?

What kind/When/Where?_____

_____

_____

11. Have you ever consulted a professional for emotional problems?

If yes, Who and when:_____

12. Do you have any caps, crowns, bridges, loose teeth or dentures?

Please list_____

13. List any medical problems_____

_____

_____

_____

14. Have you (or a relative) had a reaction from General or Local Anesthesia? Yes No

Explain _____

_____

_____

15. Reason for today's visit _____

_____

_____

OFFICE USE ONLY: HX REVIEWED BY_____**DATE**_____