Medical History Form

NAME: _____ DOB: _____

Email address: _____ How did you hear about us? _____

In case of Emergency, Notify:_____ _____ _____
Name *Relationship* *Phone*

Have you had or have:	Y	N		Y	N		Y	N
Cardiovascular Disease			Asthma			Psychiatric disorder		
High Blood Pressure			Cancer			Respiratory disease		
Rheumatic Fever			Hepatitis/Jaundice			Thyroid disease		
Heart Murmur			Sexually Transmitted disease			Tuberculosis		
Mitral Valve Prolapse			AIDS/HIV+			Stroke		
Angina			Stomach/Intestinal disease			Do you use tobacco?		
Artificial Heart Valve/Joint			Kidney disease			IF so, how much?		
Blood disease/Anemia			Diabetes			Do you drink alcohol?		
Hemophilia			High Cholesterol			IF so, how much?		

Routine Medications *(including ASPIRIN & Birth Control Pills): Write NONE if none*	*ALLERGIES (Medications, Pine Nuts, LATEX, other): Write NONE if none*

Do you use any Controlled Substance? _____
ANY other medical conditions not noted above: _____
Have you ever been hospitalized, had major operations, or serious illness? _____
If yes, please give details: _____
Are you under any medical treatment now? IF so, for what? _____
Have you ever had a blood transfusion? _____
Have you ever had kidney dialysis treatment? _____
Have you ever had abnormal bleeding problems after a cut or tooth extraction? _____
WOMEN: Is there a possibility that you are pregnant? _____ Due Date: _____

Name of your Primary Physician: _____ Phone Number: _____

_____ _____
Signature Date

_____
Reviewed by DDS