Medical Health History

Patient Name: ______________________ **Today's Date:** ____________

Reason for Today's Visit: ______________________ **Date of Birth:** ____________

Check ☑ if you have ever had any of the following. Please fill out form completely.

Allergies/Intolerance

- ☐ **NONE**
- ☐ Penicillin
- ☐ Codeine
- ☐ Latex
- ☐ Other: ____________
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Dental Anesthetic
- ☐ Iodine

Cardiovascular/Respiratory

- ☐ **NONE**
- ☐ High Blood Pressure
- ☐ Increased Cholesterol
- ☐ Congestive Heart Failure
- ☐ Infective Endocarditis
- ☐ Heart valve replacement
- ☐ Rheumatic Fever
- ☐ Atrial Fibrillation
- ☐ Lung Disease
- ☐ Emphysema
- ☐ Chronic Sinus Problems
- ☐ Stroke
- ☐ Angina
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Pacemaker
- ☐ Atherosclerosis
- ☐ Heart Murmur
- ☐ COPD
- ☐ Asthma
- ☐ Tuberculosis

Immunocompromised/Immunosuppressed

- ☐ **NONE**
- ☐ Diabetes
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Kidney Disease
- ☐ Bleeding Disorder
- ☐ Hepatitis A, B, C or other
- ☐ Sexually transmitted disease
- ☐ Thyroid disease
- ☐ Radiation Therapy
- ☐ Anemia
- ☐ Kidney Dialysis
- ☐ Blood Transfusion
- ☐ Organ Transplant
- ☐ HIV/AIDS

History of Hospitalizations and Surgeries: Please list if any

- ☐ **NONE**

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Medications

- ☐ **NONE**
- ☐ Are you currently taking any prescription, over-the-counter or herbal medications? If yes, please list them below:

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Premedication Need for Cardiac/ Joint Replacement

Does your PCP, Orthopedic Surgeon or Cardiologist request you take antibiotics for dental visits? ☐ Yes ☐ No

Musculo-Skeletal/GI/Neurological/Developmental

- ☐ **NONE**
- ☐ Joint Replacement
- ☐ Rheumatoid Arthritis
- ☐ Multiple Sclerosis
- ☐ Dementia/Alzheimer's
- ☐ Visual Impairment
- ☐ Hearing Impairment
- ☐ Mobility Impairment
- ☐ Intellectual Disability
- ☐ Osteoarthritis
- ☐ Epilepsy/Seizures
- ☐ Cerebral Palsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Spinal cord injury
- ☐ Chronic jaw pain
- ☐ GERD or Acid reflux

Psychological

- ☐ Anxiety
- ☐ Substance Abuse
- ☐ Eating Disorder
- ☐ Other: ____________
- ☐ Depression
- ☐ ADHD/ADD
- ☐ Bipolar

Pregnancy

- ☐ **N/A**
- ☐ Are you currently Pregnant? If yes, how many months: ______
- ☐ Are you currently Breastfeeding?

☐ **Do you have any other medical conditions not listed on this form? If yes, please list:** ____________

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To the best of my knowledge, all of the above answers are true.

Patient Signature: ______________________ Date: ____________

Doctor Signature: ______________________ Date: ____________