

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## MEDICAL HISTORY

Please Circle Appropriate Response:

NO YES **Are you in good general health?**  
 NO YES Are you now taking any drugs or medications?  
 Which ones? \_\_\_\_\_

NO YES Are you allergic to any medications?  
 Which ones? \_\_\_\_\_

Family Doctor: \_\_\_\_\_  
 Phone: \_\_\_\_\_

NO YES Would you object to our office contacting your family doctor in regard to any medical problem that may arise?  
 \_\_\_\_\_

condition  
 NO YES Have you ever received local anesthesia (Novocaine or Xylocaine) by a dentist or doctor?  
 NO YES Have you ever received general anesthesia?  
 NO YES Have you ever had any adverse reaction to either local or general anesthesia?  
 Please describe \_\_\_\_\_

your  
 NO YES Do you take blood thinners?  
 Which ones? \_\_\_\_\_

NO YES Do you take vitamins regularly?  
 Which ones? \_\_\_\_\_

NO YES Do you take vitamins containing Vitamin E?

NO YES Do you take aspirin products or anti-inflammatory medicines or headache medicines?  
 Which ones? \_\_\_\_\_

NO YES Do you exercise regularly?

**PLEASE LIST ALL PREVIOUS SURGERIES AND DATES:**

\_\_\_\_\_  
 \_\_\_\_\_

**DO ANY FAMILY MEMBERS HAVE: (Circle if yes)**

Heart trouble	Tuberculosis
Excessive scarring	Excessive bleeding tendency
Diabetes	Psychiatric or "nerve" problems
Adverse reactions to anesthesia	

**HAVE YOU HAD:**

NO YES Blood pressure or related problems  
 NO YES Liver, gallbladder, problems  
 NO YES "yellow Jaundice", Hepatitis problems  
 NO YES Heart trouble  
 NO YES Kidney disease  
 NO YES Diabetes  
 NO YES Stomach problems, indigestion or ulcers  
 NO YES Bleeding tendency or excessive bruising  
 NO YES Any part of your body paralyzed or numb  
 NO YES Psychiatric consultation  
 NO YES Epilepsy-convulsions or seizures  
 NO YES Broken bones of the face, neck, jaw or back  
 NO YES Back trouble  
 NO YES Abnormal chest x-rays  
 NO YES Abnormal Electrocardiogram (ECG)  
 NO YES Asthma or other respiratory problems  
 NO YES Any medical treatment for nervous

NO YES Excessive scarring  
 NO YES Tuberculosis  
 NO YES Thyroid problems  
 NO YES Any other illnesses. If so please list:  
 NO YES A gain or loss of more than 15 pounds in body weight.  
 NO YES Abdominal or inguinal hernia  
 NO YES History of blood clots in legs or lungs  
 NO YES History of legs swelling  
 NO YES Glaucoma, cataracts  
 NO YES Dry eyes  
 NO YES Herpes or Cold Sores

Other: \_\_\_\_\_

**DO YOU:**

NO YES Wear contact lenses  
 NO YES Have dentures, false teeth, caps or bridges  
 NO YES Smoke? How much? \_\_\_\_\_  
 NO YES Drink alcohol? How much? \_\_\_\_\_  
 NO YES Think you are pregnant? Date of last menstrual period \_\_\_\_\_  
 NO YES Have any contagious or infectious condition  
 NO YES Have you been exposed directly or indirectly to any one with HIV (AIDS)

The above information is strictly confidential

\_\_\_\_\_  
 Patient Signature Date

\_\_\_\_\_  
 Witness Signature Date