

## Patient Health History

Patient Name: \_\_\_\_\_ Chart # \_\_\_\_\_

Please mark "YES" or "NO" to indicate if you have had any of the following:

	YES	NO		YES	NO		YES	NO
AIDS			Epilepsy			Psychiatric care		
Anemia			Fainting or dizziness			Radiation treatment		
Arthritis, rheumatism			Glaucoma			Respiratory disease		
Artificial Heart Valves			Headaches			Rheumatic fever		
Artificial Joints			Heart Murmur			Scarlet fever		
Asthma			Heart Problems			Shortness of Breath		
Back Problems			Hepatitis, type _____			Sinus trouble		
Abnormal Bleeding/bruising			Herpes			Skin Rash		
Blood Disease			High Blood Pressure			Stroke		
Cancer			HIV-positive			Swelling feet/ankles		
Chemical Dependency			Jaundice			Thyroid problems		
Chemotherapy			Jaw Pain/stiffness			Tonsillitis		
Circulatory problems			Kidney disease			Tuberculosis		
Congenital heart lesions			Liver Disease			Tumor/growth		
Cortisone treatments			Low Blood Pressure			Ulcer		
Cough, persistant or bloody			Mitral valve prolapse			Veneral Disease		
Diabetes			Nervous Problems			Weight loss, unexplained		
Emphysema			Pacemaker					

**Allergies: Are you allergic to any medications? Penicillin YES NO Latex YES NO**

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

Do you have any other medical condition(s) or history not mentioned above? YES NO

If yes, please explain: \_\_\_\_\_

Do you drink alcohol? YES NO Do you smoke? YES NO Do you chew tobacco? YES NO

Have you been in a hospital or under the care of a physician in the past 5 years? YES NO

Have you had any operations? YES NO If yes, list: \_\_\_\_\_

Have you ever had an unfavorable reaction to local or general anesthesia? YES NO

Women: Are you pregnant? YES Due Date \_\_\_\_\_ NO

Are you taking oral contraceptives (birth control pills)? YES NO

Have you ever taken Fen-Phen? YES NO

Do you wear glasses or contacts? Glasses \_\_\_\_\_ Contacts \_\_\_\_\_

**Medications: List medications you are currently taking:** \_\_\_\_\_

The above information is completely accurate to the best of my knowledge.

\_\_\_\_\_  
Patient Signature (Parent or Guardian if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date

**If you have had any changes to your medical history within the last 3 months, you will be given a new medical history to complete to ensure your records are accurate.**