The Medical History - A Vital Record

MEDICAL HISTORY

Name of Primary-Care Physician _____ Date Last Seen _____

Office Address _____ Postal Code _____ Phone _____

DO YOU HAVE OR HAVE YOU EVER HAD (circle):

1. Hospitalization for illness or surgery ..... Yes No
2. Presently being treated for any illness ..... Yes No
3. Taking any medication regularly now or within the past year ..... Yes No
4. Aware of a change in your general health in the past year ..... Yes No
5. An allergic reaction to drug or allergy ..... Yes No
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6. Hepatitis or HIV Positive ..... Yes No
7. Jaundice (yellow skin or eyes) ..... Yes No
8. Rheumatic fever ..... Yes No
9. Scarlet fever ..... Yes No
10. Anemia or other blood disorders ..... Yes No
11. Kidney disease ..... Yes No
12. Diabetes ..... Yes No
13. Liver disease ..... Yes No
14. Heart trouble ..... Yes No
15. Asthma ..... Yes No
16. Epilepsy (fainting spells & seizures) ..... Yes No
17. Hip replacement ..... Yes No
18. Arthritis ..... Yes No
19. Prolonged bleeding due to a slight cut (bruise easily) ..... Yes No
20. Ulcer ..... Yes No
21. Tuberculosis (T.B.) ..... Yes No
22. Thyroid or parathyroid disorders ..... Yes No
23. Arteriosclerosis (hardening of the arteries) ..... Yes No
24. High blood pressure ..... Yes No
25. Low blood pressure ..... Yes No
26. Excessively swollen ankles ..... Yes No
27. A stroke ..... Yes No
28. Shortness of breath on mild exertion ..... Yes No
29. Chest pains on mild exertion ..... Yes No
30. Radiation, treatment by cobalt, radium x-ray, etc ..... Yes No
31. Glaucoma ..... Yes No
32. Aware of any recent weight change ..... Yes No
33. Often thirsty ..... Yes No
34. Often exhausted or fatigued ..... Yes No
35. Subject to frequent headaches ..... Yes No

IF FEMALE, ARE YOU NOW:

36. Pregnant ..... Yes No
37. Taking birth control pills or other hormones ..... Yes No

COMMENTS

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IF THERE IS ANY CHANGES IN MY MEDICAL HISTORY, I WILL NOTIFY THE DENTIST.

PATIENT'S SIGNATURE: _____ DATE: _____

Reviewed by _____	Date _____	Reviewed by: _____	Date: _____	Reviewed by: _____	Date _____
Reviewed by _____	Date _____	Reviewed by: _____	Date: _____	Reviewed by: _____	Date _____
Reviewed by _____	Date _____	Reviewed by: _____	Date: _____	Reviewed by: _____	Date _____
Reviewed by _____	Date _____	Reviewed by: _____	Date: _____	Reviewed by: _____	Date _____

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