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

22. Arthritis ..... Yes No
23. Prolonged bleeding due to a slight cut (bruise easily) ..... Yes No
24. Ulcer ..... Yes No
25. Tuberculosis (T.B.) ..... Yes No
26. Thyroid or parathyroid disorders ..... Yes No
27. Arteriosclerosis (hardening of the arteries) ..... Yes No
28. High blood pressure ..... Yes No
29. Low blood pressure ..... Yes No
30. Excessively swollen ankles ..... Yes No
31. A stroke ..... Yes No
32. Shortness of breath on mild exertion ..... Yes No
33. Chest pains on mild exertion ..... Yes No
34. Radiation, treatment by cobalt, radium x-ray, etc ..... Yes No
35. Glaucoma ..... Yes No
36. Aware of any recent weight change ..... Yes No
37. Often thirsty ..... Yes No
38. Often exhausted or fatigued ..... Yes No
39. Subject to frequent headaches ..... Yes No

ARE YOU NOW:

18. Pregnant ..... Yes No

Taking birth control pills or other hormones ..... Yes No

19. Do you smoke cigarettes/cigars ..... Yes No

How many per day? _____ For how many years have you smoked? _____

20. Do you drink alcohol. ..... Yes No

How many drinks per week? _____

21. Do you use recreational drugs ..... Yes No

Please list substances/how often weekly? _____

_____

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: _____

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