

Medical History Form

Name: _____ Date filled out: _____

Please list the number you prefer us to call with test results: _____

Primary care physician: _____

Do you now have, or have you ever been diagnosed with any of the following conditions:

Respiratory:	YES	NO	Eyes:	YES	NO
Asthma -----	<input type="checkbox"/>	<input type="checkbox"/>	Itching or burning-----	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema-----	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine:		
Chronic cough-----	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes-----	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath-----	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease-----	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:			Genitourinary:		
High Blood Pressure-----	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bladder infection-	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat-----	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease-----	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack-----	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal:		
Artificial Heart Valve-----	<input type="checkbox"/>	<input type="checkbox"/>	Stomach upset from antibiotics--	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker/Defibrillator--	<input type="checkbox"/>	<input type="checkbox"/>	Frequent heartburn-----	<input type="checkbox"/>	<input type="checkbox"/>
Hematology:			Musculoskeletal:		
Blood clots-----	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis-----	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia-----	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness/pain----	<input type="checkbox"/>	<input type="checkbox"/>
Neurology:			Artificial Joint(s)-----	<input type="checkbox"/>	<input type="checkbox"/>
Depression-----	<input type="checkbox"/>	<input type="checkbox"/>	Immune system/Infection:		
Seizures-----	<input type="checkbox"/>	<input type="checkbox"/>	Viral Hepatitis-----	<input type="checkbox"/>	<input type="checkbox"/>
Gynecology: (Females only)			HIV/AIDS-----	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Yeast infections-	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis-----	<input type="checkbox"/>	<input type="checkbox"/>
Currently Pregnant-----	<input type="checkbox"/>	<input type="checkbox"/>	Weak immune system----	<input type="checkbox"/>	<input type="checkbox"/>
If yes, Due Date: _____					

Oncology:

Have you ever been diagnosed with cancer? (Don't include skin cancer) YES NO

If yes, what type(s) of cancer: _____

Have you ever had skin cancer? YES NO

If yes, please circle what type(s): Basal Cell / Squamous cell / Melanoma / Not sure

Have any of your blood relatives been diagnosed with Melanoma? YES NO

Skin: Do you develop thick scars after surgery? YES NO Not Sure

Social History:

Do you sunbathe or use tanning beds? YES NO

Do you drink alcohol? YES NO-----If yes, _____drinks per day

Do you smoke? YES NO-----If yes, _____packs per day

What is your occupation? _____

Have you ever had a bad reaction to local anesthesia? YES NO Not sure

Have you been told to take antibiotics prior to dental or surgical procedures? YES NO Not sure

LIST ANY MEDICATION ALLERGIES: _____

CURRENT MEDICATIONS: _____

Is it ok to discuss your diagnosis and treatment with a significant other? YES NO (Initial here: _____)

If yes, please list the name and relationship: _____