Medical History

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? ☐ YES ☐ NO If yes, list:

List Current Allergies: _____

Are you taking any medications? ☐ YES ☐ NO If yes, list:

List Current Medications: _____

Are you experiencing any chronic pain? ☐ YES ☐ NO

Please check YES or NO if you have/do/are the following:

	YES	NO		YES	NO
Fever	☐	☐	Drink alcohol	☐	☐
Weight loss	☐	☐	Smoke tobacco	☐	☐
Bleed easily	☐	☐	Pregnant (women)	☐	☐
Artificial joints	☐	☐	Diabetes	☐	☐
Joint Pain	☐	☐	Pacemaker/Defibrillator	☐	☐
Thyroid Disease	☐	☐	HIV (AIDS)	☐	☐
Anxiety	☐	☐	Hepatitis	☐	☐
Artificial heart valves	☐	☐	If yes, what kind _____		

Have you ever had a bad reaction to dental anesthesia (Novacaine)? ☐ YES ☐ NO
Do you have a history of falling? ☐ YES ☐ NO
If yes, feel free to call the office for assistance from your vehicle.

Skin:

When exposed to sun do you: ☐ Tan only ☐ Tan and burn ☐ Burn

Have you ever had skin cancer? ☐ YES ☐ NO
If yes what kind was it?_____

Has anyone in your family had skin cancer? ☐ YES ☐ NO

Do you have any specific skin diseases? ☐ YES ☐ NO

If yes, please list: _____

List any other disease or condition we should know about: _____

List surgical procedures you have had in the last 6 months: _____