# MEDICAL HEALTH HISTORY

**Are you taking medications, vitamins or herbs? Yes or No**

**If yes, please list current medications, vitamins & herbs:** _____

_____

_____

_____

**Do you have any of the following? Check all that apply and provide additional information as needed.**

**Heart**

- ☐ ☐ Angina
- ☐ ☐ Artificial heart valves
- ☐ ☐ Arteriosclerosis
- ☐ ☐ Blood pressure: High or Low
- ☐ ☐ Cardiovascular Disease
- ☐ ☐ Chest pain upon exertion
- ☐ ☐ Congestive heart failure or defects
- ☐ ☐ Coronary artery disease
- ☐ ☐ Heart attack
- ☐ ☐ Heart murmur
- ☐ ☐ Pacemaker

**Blood**

- ☐ ☐ Excessive bleeding
- ☐ ☐ Anemia or Hemochromatosis
- ☐ ☐ Easy bruising
- ☐ ☐ AIDS or HIV infection

**Respiratory**

- ☐ ☐ Asthma
- ☐ ☐ Bronchitis
- ☐ ☐ Cough that produces blood
- ☐ ☐ Hay fever/seasonal/animal/food allergies
- ☐ ☐ Persistent cough longer than 3 weeks
- ☐ ☐ Sinus problems
- ☐ ☐ Tuberculosis or been exposed to TB

**General Questions**

- ☐ ☐ History of severe head or mouth injury?
  Explain:_____
  _____
- ☐ ☐ History of drug or alcohol abuse?
- ☐ ☐ Do you Smoke? If yes, how much?
- ☐ ☐ Do you need antibiotics for dental treatment?

**Women Only**

- ☐ ☐ Are you taking contraceptives/hormones?
- ☐ ☐ Are you pregnant or nursing?

**Diseases & Conditions**

- ☐ ☐ Arthritis
- ☐ ☐ Autoimmune disease:
- ☐ ☐ Cancer/Chemo/Radiation Treatment
- ☐ ☐ Diabetes: Type I or Type II
- ☐ ☐ Eating Disorder: _____
- ☐ ☐ Fainting spells/Seizures/Epilepsy
- ☐ ☐ Gastrointestinal disorder
- ☐ ☐ Glaucoma
- ☐ ☐ Headaches severe/migraines
- ☐ ☐ Herpes
- ☐ ☐ Hepatitis
- ☐ ☐ Joint Replacement: Total or Hemi
  If yes, joint: _____ date:_____
- ☐ ☐ Kidney or Bladder problems
- ☐ ☐ Mental health disorder: _____
  _____
- ☐ ☐ Neurological disorder: _____
  _____
- ☐ ☐ Osteoporosis
- ☐ ☐ Stroke
- ☐ ☐ Thyroid problems
- ☐ ☐ Do you have disease/condition(s) not listed?
  If yes, please list:_____
  _____

**Allergic Reactions**

- ☐ ☐ Local anesthetics ("Novacaine")
- ☐ ☐ Penicillin
- ☐ ☐ Sulfa drugs
- ☐ ☐ Other Antibiotic: _____
- ☐ ☐ Barbiturates, seditives, sleeping pills
- ☐ ☐ Aspirin, Acetaminophin, Ibuprofen
- ☐ ☐ Codeine, Demerol, other narcotics
- ☐ ☐ Metals reaction
- ☐ ☐ Latex or rubber dam
- ☐ ☐ Iodine
- ☐ ☐ List Other Allergies: _____
  _____

**I certify that the information on this form is true and correct.**

**Signature (Responsible Party):** _____ **Date:** _____

**Relationship to patient:**_____