

**Date:**  
**Updated:**

**Medical History**  
**(Patient to Complete)**

Name: \_\_\_\_\_  
Previous Surgery: \_\_\_\_\_  
Drug Allergies: \_\_\_\_\_

Habits: Alcohol: Never Rarely Daily Cigarettes: Have you ever Smoked Y/N  
What Street Drugs \_\_\_\_\_ Packs Per day \_\_\_ Age Started \_\_\_ Age Quit \_\_\_

Have you ever had: (please give details)

Surgery requiring anesthesia	yes	no	_____
Complications from surgery or anesthesia	yes	no	_____
Pneumonia	yes	no	_____
Rheumatic Fever or Heart Disease	yes	no	_____
Chest Pain/Heart Attack/ Angina	yes	no	_____
Shortness of Breath	yes	no	_____
Fainting Spells	yes	no	_____
Palpitations of Heart Flutters	yes	no	_____
Anemia	yes	no	_____
Jaundice or Liver Disease	yes	no	_____
Diabetes	yes	no	_____
High Blood Pressure	yes	no	_____
Blood Transfusion	yes	no	_____
Hives	yes	no	_____
Asthma or Hay Fever	yes	no	_____
Frequent Colds or Sore Throat	yes	no	_____
Chronic or Frequent Cough	yes	no	_____
Blood Clots	yes	no	_____
Poor Circulation	yes	no	_____
Cancer	yes	no	_____
Frequent Skin Sores	yes	no	_____
Are you or could you be pregnant	yes	no	_____

Do you have:  
Dentures                      Bridges                      Capped Teeth                      Loose Teeth      Hearing Aid  
Contact Lenses              Diseased Gums

Name: \_\_\_\_\_

Has anyone in your immediate family (mother father sister, brother) had:

Complications from surgery or anesthesia	yes	no	_____
Chest Pain/Heart Attack/Angina	yes	no	_____
Shortness of Breath/Breathing Problems	yes	no	_____
Fainting Spells	yes	no	_____
Palpitations of Heart Flutters	yes	no	_____
Anemia	yes	no	_____
Jaundice or Liver Disease	yes	no	_____
Diabetes	yes	no	_____
High Blood Pressure	yes	no	_____
Blood Transfusion	yes	no	_____
Hives	yes	no	_____
Asthma or Hay Fever	yes	no	_____
Cancer	yes	no	_____
History of Arthritis	yes	no	_____

Medication List Please Bring Bottles In:

	Name	Strength	How many times a day	Prescribing Doctor
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____

Name of Family Doctor or Referring Doctor: \_\_\_\_\_

Form Completed By: \_\_\_\_\_