

Patient History Form:
Please fill out your medical history

Name: _____ Date: _____

Phone: _____ Sex: Male Female Date of Birth: _____

Please list all Allergies: None Please list all Medications: None

Latex?	Yes	No	Aspirin?	Yes	No
1.			1.		
2.			2.		
3.			3.		
4.			4.		
5.			5.		
6.			6.		
7.			7.		

Past Medical History

	Yes	No
High Blood Pressure		
Diabetes		
Heart Trouble		
Chest Pain		
Heart Failure		
Irregular Beats		
Heart Attack		
Lung Problems		
Shortness of Breath		
Asthma		
Liver Disease		
Hepatitis		
Cirrhosis		
Kidney Failure		
Bleeding Disorder		
Blood Clots		
Pulmonary Embolus		
Previous Cancers Which one?		

What Surgeries have you had?

Year	Operation

Have you ever been Hospitalized?

Year	Reason Hospitalized

- How many Alcoholic drinks per week do you consume? _____ drinks per week.
- Tobacco/Smoking History: I have never smoked.
 Yes, I smoke _____ packs/day.
 Yes, but I quit _____ yrs ago. I used to smoke _____ packs/day.
- Do you take antibiotics before dental work? No Yes, why? _____