

PATIENT MEDICAL HISTORY

| | | | | | |
|------------------------------------|--------------------|----------------------|----------------------------|---|------------------------|
| Patient's Name: | | | | For Office Use Only | |
| | | | | ID: <input style="width: 50px;" type="text"/> | |
| Address: | | Today's Date: | Date of Last Visit: | Date of Med. History: | |
| | | | | | |
| City State Zip: | | | Email: | | |
| | | | | | |
| Home Phone: | Work Phone: | Cell Phone: | Birth Date: | Social Security No.: | Marital Status: |
| | | | | | |
| Primary Dental Guarantor: | | Home Phone: | Work Phone: | Cell Phone: | |
| | | | | | |
| Secondary Dental Guarantor: | | Home Phone: | Work Phone: | Cell Phone: | |
| | | | | | |
| Physician Name: | | | Physician Phone: | | |
| | | | | | |
| Pharmacy: | | | Pharmacy Phone: | | |
| | | | | | |

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y N

- Are you taking Birth Control Pills?
- Are you pregnant? If Yes, # of weeks
- Are you nursing?

Please answer the following:

Y N

- Do you smoke or use tobacco? Height:
- For Office Use Only**
- BP: Heart Rate: Weight:

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|-------------------------|-------------------|---|-------------------|---|---------------|---|-----------|---|--------|---|-----------------|---|-----------|---|------------------------|---|--------|---|-------------------|---|----------------------|---|---------|---|-------------------------|---|------------------|---|----------|---|----------------------|---|------------|---|-----------|---|----------|---|-----------------|---|----------------|---|--------------------|---|----------|--|-----|-------------------|---|-----------|---|-----------|---|--------------|---|---------------|---|------------|---|-------------|---|-------------|---|---------------------|---|-------------------|---|-----------------|---|---------------|---|--------------------|---|-----------------------|---|------------|---|----------------|---|----------------------|---|-------------------|---|-----------------|---|----------|---|----------|---|---------------------|---|----------------|---|-----|-------------------|---|--------|---|------------------|---|--------------|---|--------|---|------------------|---|-----------------|-----|------------------|---|---------|---|---------|---|--------------------|---|--------------|---|---------|---|-------|---|--------|---|------------|---|--------------|--------------|--|-------|--|-------|--|
| <table border="0"> <tr><td>Y N</td><td>Conditions</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Abnormal Bleeding</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Alcohol Abuse</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Allergies</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Anemia</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Angina Pectoris</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Artificial Heart Valve</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Asthma</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Blood Transfusion</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Cancer- Chemotherapy</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Colitis</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Congenital Heart Defect</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Cosmetic Surgery</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Diabetes</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Difficulty Breathing</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Drug Abuse</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Emphysema</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Epilepsy</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Fainting Spells</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Fever Blisters</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Frequent Headaches</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Glaucoma</td></tr> </table> | Y N | Conditions | <input type="checkbox"/> <input type="checkbox"/> | Abnormal Bleeding | <input type="checkbox"/> <input type="checkbox"/> | Alcohol Abuse | <input type="checkbox"/> <input type="checkbox"/> | Allergies | <input type="checkbox"/> <input type="checkbox"/> | Anemia | <input type="checkbox"/> <input type="checkbox"/> | Angina Pectoris | <input type="checkbox"/> <input type="checkbox"/> | Arthritis | <input type="checkbox"/> <input type="checkbox"/> | Artificial Heart Valve | <input type="checkbox"/> <input type="checkbox"/> | Asthma | <input type="checkbox"/> <input type="checkbox"/> | Blood Transfusion | <input type="checkbox"/> <input type="checkbox"/> | Cancer- Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> | Colitis | <input type="checkbox"/> <input type="checkbox"/> | Congenital Heart Defect | <input type="checkbox"/> <input type="checkbox"/> | Cosmetic Surgery | <input type="checkbox"/> <input type="checkbox"/> | Diabetes | <input type="checkbox"/> <input type="checkbox"/> | Difficulty Breathing | <input type="checkbox"/> <input type="checkbox"/> | Drug Abuse | <input type="checkbox"/> <input type="checkbox"/> | Emphysema | <input type="checkbox"/> <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> <input type="checkbox"/> | Fainting Spells | <input type="checkbox"/> <input type="checkbox"/> | Fever Blisters | <input type="checkbox"/> <input type="checkbox"/> | Frequent Headaches | <input type="checkbox"/> <input type="checkbox"/> | Glaucoma | <table border="0"> <tr><td>Y N</td><td>Conditions</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>HIV+ AIDS</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Hay Fever</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Heart Attack</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Heart Surgery</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Hemophilia</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Hepatitis A</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Hepatitis B</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>High Blood Pressure</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Joint Replacement</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Kidney Problems</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Liver Disease</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Low Blood Pressure</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Mitral Valve Prolapse</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Pace Maker</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Pneumocystitis</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Psychiatric Problems</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Radiation Therapy</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Rheumatic Fever</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Seizures</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Shingles</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Sickle Cell Disease</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Sinus Problems</td></tr> </table> | Y N | Conditions | <input type="checkbox"/> <input type="checkbox"/> | HIV+ AIDS | <input type="checkbox"/> <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> <input type="checkbox"/> | Heart Surgery | <input type="checkbox"/> <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> <input type="checkbox"/> | Hepatitis A | <input type="checkbox"/> <input type="checkbox"/> | Hepatitis B | <input type="checkbox"/> <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> | Joint Replacement | <input type="checkbox"/> <input type="checkbox"/> | Kidney Problems | <input type="checkbox"/> <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> | Pace Maker | <input type="checkbox"/> <input type="checkbox"/> | Pneumocystitis | <input type="checkbox"/> <input type="checkbox"/> | Psychiatric Problems | <input type="checkbox"/> <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> | Seizures | <input type="checkbox"/> <input type="checkbox"/> | Shingles | <input type="checkbox"/> <input type="checkbox"/> | Sickle Cell Disease | <input type="checkbox"/> <input type="checkbox"/> | Sinus Problems | <table border="0"> <tr><td>Y N</td><td>Conditions</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Stroke</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Thyroid Problems</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Tuberculosis</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Ulcers</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Venereal Disease</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Yellow Jaundice</td></tr> </table> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <table border="0"> <tr><td>Y N</td><td>Allergies</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Aspirin</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Codeine</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Dental Anesthetics</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Erythromycin</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Jewelry</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Latex</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Metals</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Penicillin</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/></td><td>Tetracycline</td></tr> <tr><td colspan="2">Other</td></tr> <tr><td colspan="2">_____</td></tr> <tr><td colspan="2">_____</td></tr> </table> </div> | Y N | Conditions | <input type="checkbox"/> <input type="checkbox"/> | Stroke | <input type="checkbox"/> <input type="checkbox"/> | Thyroid Problems | <input type="checkbox"/> <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> | Ulcers | <input type="checkbox"/> <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> <input type="checkbox"/> | Yellow Jaundice | Y N | Allergies | <input type="checkbox"/> <input type="checkbox"/> | Aspirin | <input type="checkbox"/> <input type="checkbox"/> | Codeine | <input type="checkbox"/> <input type="checkbox"/> | Dental Anesthetics | <input type="checkbox"/> <input type="checkbox"/> | Erythromycin | <input type="checkbox"/> <input type="checkbox"/> | Jewelry | <input type="checkbox"/> <input type="checkbox"/> | Latex | <input type="checkbox"/> <input type="checkbox"/> | Metals | <input type="checkbox"/> <input type="checkbox"/> | Penicillin | <input type="checkbox"/> <input type="checkbox"/> | Tetracycline | Other | | _____ | | _____ | |
| Y N | Conditions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Abnormal Bleeding | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Alcohol Abuse | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Allergies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Anemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Angina Pectoris | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Arthritis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Artificial Heart Valve | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Asthma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Blood Transfusion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Cancer- Chemotherapy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Colitis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Congenital Heart Defect | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Cosmetic Surgery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Diabetes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Difficulty Breathing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Drug Abuse | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Emphysema | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Epilepsy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Fainting Spells | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Fever Blisters | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Frequent Headaches | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Glaucoma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N | Conditions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | HIV+ AIDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Hay Fever | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Heart Attack | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Heart Surgery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Hemophilia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Hepatitis A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Hepatitis B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | High Blood Pressure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Joint Replacement | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Kidney Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Liver Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Low Blood Pressure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Mitral Valve Prolapse | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Pace Maker | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Pneumocystitis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Psychiatric Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Radiation Therapy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Rheumatic Fever | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Seizures | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Shingles | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Sickle Cell Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Sinus Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N | Conditions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Stroke | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Thyroid Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Tuberculosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Ulcers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Venereal Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Yellow Jaundice | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N | Allergies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Aspirin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Codeine | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Dental Anesthetics | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Erythromycin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Jewelry | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Latex | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Metals | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Penicillin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> | Tetracycline | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Medications:

| | | |
|--|--|--|
| | | |
|--|--|--|

Y N

Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below...

| |
|--|
| |
|--|

Notes:

| |
|--|
| |
|--|

Signature: _____

Date: _____

(If Under 18, Parent or Guardian Signature Required)