



MEDICAL HISTORY FORM

Name: _____ **Today's Date:** _____

Time frame considering for surgery: [] within 2 months [] within 6 months [] over a year

Date of Birth: ___/___/_____ **Sex:** M / F **Height:** ___' ___" **Weight:** ___ lbs

**For the following questions, circle yes or no, whichever applies to your medical history.
Your answers are for our records only and will be considered confidential.**

1. Are you in good health? Yes No

2. Has there been any change in your health in the past year? Yes No

3. My last physical exam was on ___/___/_____ By Whom: _____

4. Are you now under the care of a physician? Yes No
 If so, for what condition(s)? _____

5. The name and address of my physician is: _____

6. Have you had any serious illness, significant operation or hospitalization within the past 5 years?..... Yes No
 If yes, please explain _____

7. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills..... Yes No
 If yes, please list _____

8. Do you have or have you had any of the following diseases or problems?

a. Damaged heart valves, artificial valves or heart murmur	Yes	No
b. Rheumatic Heart Disease.....	Yes	No
c. Heart trouble, heart attack, angina, high blood pressure, stroke, Arteriosclerosis or any other heart condition.....	Yes	No
1. Chest pain upon exertion?	Yes	No
2. Shortness of breath after mild exercise?.....	Yes	No

3. Do your ankles swell?	Yes	No
d. Allergies	Yes	No
e. Sinus trouble	Yes	No
f. Asthma or hay fever.....	Yes	No
g. Fainting spells or seizures	Yes	No
h. Diabetes.....	Yes	No
i. Hepatitis, jaundice or liver disease	Yes	No
j. Frequent or recurring mouth sores	Yes	No
k. Thyroid problems	Yes	No
l. Respiratory problems, emphysema, bronchitis, etc.....	Yes	No
m. Arthritis or painful, swollen joints including jaw joint (TMJ).....	Yes	No
n. Stomach ulcer or hyperacidity	Yes	No
o. Kidney trouble.....	Yes	No
p. Tuberculosis.....	Yes	No
q. Persistent cough and/or cough that produces blood	Yes	No
r. Persistent swollen neck glands.....	Yes	No
s. Low blood pressure.....	Yes	No
t. Epilepsy or neurological disorder.....	Yes	No
u. Are you taking vitamins or homeopathic remedies.....	Yes	No
v. Cancer History.....	Yes	No
w. Any disease, drug or transplant operation that has depressed your immune system	Yes	No
9. Have you had abnormal bleeding?	Yes	No
a. Have you ever required a blood transfusion?.....	Yes	No
10. Do you have any blood disorder such as anemia?	Yes	No
11. Have you ever had treatment for a tumor or growth?	Yes	No
12. Are you allergic to or have you had a reaction to:		
a. Local anesthetics	Yes	No
b. Penicillin or antibiotics.....	Yes	No
c. Sulfa drugs.....	Yes	No
d. Barbiturates or sleeping pills.....	Yes	No
e. Aspirin	Yes	No
f. Iodine	Yes	No
g. Codeine or other narcotics.....	Yes	No
h. Latex or rubber products.....	Yes	No
i. Other	Yes	No
what? _____		
13. Do you have any other condition or disease you think the doctor should know about?.....	Yes	No
If so, explain: _____		
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14. Are you / do you wearing contact lenses?	Yes	No
15. Are you / do you wearing removable dental appliances?	Yes	No
16. Do you wish to talk with the doctor privately about anything?	Yes	No
17. Have you ever struggled with an addiction such as alcohol, drugs, cigarettes. Yes	Yes	No
If so please explain : _____		
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Women Only (Please answer below)

- 1. Are you pregnant or trying to become pregnant? Yes No
- 2. Do you have problems associated with your menstrual period? Yes No
- 3. Are you nursing? Yes No
- 4. Are you taking birth control pills? Yes No
- 5. You are the birth mother of how many children? 1 2 3 4 5 6 7 8
- 6. Have you had a C-section with any of your children? Yes No
- 7. Do you experience any abdomen pain? Yes No

Please sign and date that you have read and filled out 3 pages in total.

I certify that I have read and understand the above information and have filled it out completely and honestly. I acknowledge that my questions, if any, have been marked with a (*) next to the question, and about the inquiries set forth above I have met with the physician, and each has been answered to my satisfaction. I will not hold my doctor, or any member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Patient's Signature: _____

Date: _____ Doctor's Signature: _____