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PATIENT MEDICAL INFORMATION

Name(print) _____ Age _____ Weight _____ Height _____

Reason(s) for your visit: _____

Prior consultation, treatment or surgery for this condition? [Yes] [No]

Please note physician seen & when: _____

Were you referred to our office? [Yes] [No]

If yes, by whom: _____

MEDICAL & SURGICAL HISTORY *Please answer *or* check all questions!

Allergic to Penicillin [Yes] [No] Type of reaction: _____

If yes, please note which antibiotics you have taken w/out reaction: _____

Are you allergic or sensitive to any other medications or drugs? [Yes] [No]

If yes, which medication(s) & type of reaction(s)? _____

Have you ever had Epinephrine/Local Anesthesia [Yes] [No] General Anesthesia [Yes] [No]

Did you have a bad reaction? [Yes] [No] Please describe reaction _____

Do you use: Tobacco [Never] [Yes] Packs per day _____ Discontinued when _____

Alcohol [Yes] [No] If yes, average daily consumption _____ Coffee/Tea _____

MEDICATIONS: *If taken within the last 4 weeks

Aspirin [Yes] [No] Anti-inflammatory drugs (Advil/Motrin) [Yes] [No]

Vitamin E [Yes] [No] Other Vitamins or Herbs [Yes] [No] Please list: _____

Prescription & Non-Prescription Drugs taken?

Medication: _____ For What Condition? _____ Dose _____

ILLNESSES OR DISORDERS: Do you have now, or have you ever had:

Cancer [Yes] [No] Describe type: _____

Mitral Valve Prolapse [Yes] [No] Type of antibiotic recommended & dose? _____

Thyroid Disorder [Yes] [No] Type of medication? _____

Psychiatric Disorder [Yes] [No] Type of disorder & medication? _____

High Blood Pressure [Yes] [No]

Heart Attack [Yes] [No]

Heart Murmur [Yes] [No]

Diabetes [Yes] [No]

Lung disease [Yes] [No]

Kidney disease [Yes] [No]

Stomach/Bowel Disease [Yes] [No]

Prolonged Bleeding/Bruising [Yes] [No]

Other medical disorders, injuries or serious illnesses requiring hospitalization (describe & year):

PREVIOUS SURGERIES

Please list all procedures: _____

Females: Pregnant [Yes] [No] Breast Feeding [Yes] [No] Menopausal [Yes] [No]