

# MEDICAL HEALTH HISTORY

Do you have, or have you had, any of the following?

FORM 2 of 3

	Yes	No		Yes	No
<b>High Blood Pressure</b>			<b>History of Rheumatic fever</b>		
Is it currently under control?	-	-	When? _____	-	-
Last checked _____	-	-	<b>Diagnosed with Hepatitis</b>	-	-
<b>Heart Disease</b>			When? _____		
Is it currently under control?	-	-	Type? _____		
Last checked _____			<b>Diagnosed with HIV/AIDS</b>	-	-
<b>Stroke</b>			When? _____		
When? _____			<b>Autoimmune Disorders</b> (Lupus, etc.)	-	-
<b>Heart Murmur</b>			<b>Chemotherapy or Radiation Therapy</b>	-	-
When was it diagnosed? _____			When? _____		
How was it diagnosed? _____			Reason? _____		
Any follow-up tests?	-	-	<b>History of Smoking?</b>	-	-
<b>Prolapsed Mitral Valve</b>			How much? _____		
When was it diagnosed? _____			For how long? _____		
How was it diagnosed? _____			Still smoking?	-	-
Any follow-up tests?	-	-	<b>Allergy or Sensitivity to Latex</b>	-	-
<b>Seizures or Epilepsy</b>			What happened? _____		
Last Seizure? _____			_____		
<b>Diabetes</b>			<b>Asthma/Respiratory Disorders</b>	-	-
When was it diagnosed? _____			When was it diagnosed? _____		
How is it controlled? _____			How is it controlled? _____		
<b>Fainting or Dizziness</b>					
When? _____	-	-			
Any diagnosis or treatment for this condition? _____					
<b>Do you drink alcohol?</b>	-	-			
How many alcoholic beverages do you consume in an average week? _____					
<b>History of Psychiatric Care</b>					
Currently?	-	-			
Medications _____					
<b>Joint Replacement Surgery</b>					
When? _____	-	-			
Treating Surgeon's Name & City _____					
<b>Surgical Pins/Rods Placed?</b>					
When? _____	-	-			
Treating Surgeon's Name & City _____					
<b>Has your physician mentioned the need for antibiotics when you visit the dentist?</b>				-	-
<b>History of ailments or diagnosis not listed affecting the:</b>			<b>If yes, please explain:</b>		
Liver	-	-	_____		
Joints	-	-	_____		
Lungs	-	-	_____		
Heart	-	-	_____		
Gastrointestinal	-	-	_____		
Eyes	-	-	_____		
Ears	-	-	_____		
Nose	-	-	_____		
Throat	-	-	_____		
<b>Allergies:</b> _____					
<b>Current Medications:</b> _____					

Signature (Guardian if patient is a minor) \_\_\_\_\_ Date \_\_\_\_\_