MEDICAL HISTORY

Patient: _____

Physician's (MD) name : _____

Physician's office location : _____

yes no Are you under a physician's care now?

yes no Have you ever had a serious illness or major surgery?
If yes, please explain: _____

yes no Are you taking any medications or drugs, *including aspirin*?
If yes, please list them below:

Medication or Drug	Dosage	Frequency	Condition taking for
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

yes no Are you allergic to any medications or health-related substances?
If yes, please list them: _____

yes no Are you allergic to or sensitive to latex or some metals?

yes no Do you have any other allergies? If yes, please list them: _____

yes no Do you have any problems with antibiotics, pain medications, anesthetics or other medications?

yes no Do you take aspirin frequently or on a daily basis?

yes no Do you take or have you taken any medication for osteoporosis?

yes no Do you have any heart problems, such as coronary artery disease or angina?

yes no Have you ever had a heart attack or heart surgery, such as bypass surgery or angioplasty?

yes no Do you have high blood pressure?

yes no Do you have any blood disorders, such as anemia or leukemia?

yes no Do you bleed excessively after being cut or injured?

yes no Do you have a heart murmur or a heart valve problem?

yes no Do you have a pacemaker or an artificial heart valve?

yes no Do you need to take antibiotics before dental treatment for a heart valve or an artificial joint?

yes no Do you have any lung or respiratory problems?

yes no Do you have asthma?

yes no Do you have any stomach or digestion problems?

yes no Are you diabetic?

yes no Do you have any kidney or urinary problems?

yes no Do you have any liver problems or liver disease?

yes no Do you have any nerve or nervous system problems?

yes no Do you have epilepsy or some other seizure disorder?

yes no Have you had psychiatric treatment?

yes no Do you have arthritis or rheumatism?

yes no Do you have any artificial joints? If yes, please indicate which joint(s): _____

yes no Have you had radiation treatment or chemotherapy for a tumor, growth or other condition?

yes no Do you have or have you had cancer? If yes, please explain: _____

yes no Do you have or have you had any type of hepatitis. If yes, please explain: _____

yes no Do you have or have you had tuberculosis (TB)?

yes no Are you HIV positive?

yes no Do you have AIDS?

yes no Do you smoke cigarettes? If yes, how much do you smoke on a typical day? _____

yes no Do you use other forms of tobacco, such as cigars, a pipe or chewing tobacco?

yes no Do you consume alcoholic beverages?

yes no *Women:* Are you pregnant or think you might be?

yes no *Women:* Do you use birth control pills?

yes no Do you have any disease, problem or condition not listed above?

yes no Is there anything else about your health that is not covered on this form that Dr. Lewis should know?

I certify that the information on this form is complete and accurate.

Patient's/Guardian's signature: _____ Date: _____