

MEDICAL HISTORY

Physician Name: _____

Address: _____

Telephone Number _____

Have you ever had, been treated for, or told that you had:
(please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hip/Knee Replacement | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Heart Valve Replacement |
| <input type="checkbox"/> At-birth Heart Defect/Surgery | <input type="checkbox"/> Infective Endocarditis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Atrial Fibrillation | | |
| <input type="checkbox"/> Other Heart Problems _____ | | |
| <input type="checkbox"/> Heart Surgery - Date: _____ | | |
| <input type="checkbox"/> Transplant Surgery - Date _____ | | |
| <input type="checkbox"/> Other Surgeries - _____ | | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Malignancies | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Angina | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Chemo Therapy |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Nervous Problems |
| <input type="checkbox"/> Asthma/Emphysema | <input type="checkbox"/> Diet Pills/Phen-Fen | <input type="checkbox"/> Do you Smoke? |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Chew Tobacco? |
| <input type="checkbox"/> Sinus Problems | | |

***Have you ever needed to be pre-medicated with antibiotics for dental work?** _____

Please check off any medications you are presently taking:

- Blood Pressure
 Blood Thinner
 Birth Control Pills

Please list any other medications you are taking:

Allergies to any medicines? (e.g. Penicillin, Codeine, Aspirin, Novocaine, etc.)
(explain) _____

If Female: Are you pregnant or contemplating pregnancy? _____
Nursing? _____

Any other conditions? _____

Signature: _____ **Date:** _____ **B.P.** _____