Confidential Medical/Health History

*****Please review the following list and *check all items* appropriate to your medical history.*****

PAST MEDICAL HISTORY

Medical Condition	Yes	No
High Blood Pressure	☐	☐
Stroke or TIA's	☐	☐
Heart Murmur	☐	☐
Heart Disease	☐	☐
Heart Attack	☐	☐
Heart Failure	☐	☐
Artificial Valve	☐	☐
Heart Flutter	☐	☐
Angina (Chest Pains)	☐	☐
Lung Disease	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Chronic Bronchitis	☐	☐
Chest Cold Last 3 Weeks	☐	☐
Bleeding Problems	☐	☐
Seizures	☐	☐
Thyroid Disease	☐	☐
Kidney Disease	☐	☐
Do you take Dialysis?	☐	☐
Liver Diseases	☐	☐
Hepatitis	☐	☐
Ulcers	☐	☐
Reflux Disease	☐	☐
Depression	☐	☐
Anxiety Attacks	☐	☐
Arthritis	☐	☐
Artificial Joint(s)	☐	☐
Cancer	☐	☐
Chemotherapy	☐	☐
Radiation Treatment	☐	☐
Are you Pregnant?	☐	☐
Diabetes (High Blood Sugar)	☐	☐
Do you use Insulin?	☐	☐
If so, what type & amt. _____		
Do you wear contacts?	☐	☐

Please write in any condition that applies to you that may have not been listed:

_____

_____

MEDICATIONS

Please list any medications you take including aspirin and birth control pills:

_____

_____

_____

_____

SOCIAL

Do you smoke? ☐ Yes ☐ No

If yes, how many packs per day?

_____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often?

MEDICATION/FOOD ALLERGIES

Please list any **medications or foods** to which you are allergic:

_____

_____

Are you allergic to Latex? ☐ Yes ☐ No

PAST SURGICAL HISTORY

Past Surgery	Yes	No	Year
Tonsillectomy	☐	☐	
Appendectomy	☐	☐	
Ear Tubes	☐	☐	
Angioplasty	☐	☐	
Hysterectomy	☐	☐	
Tubal Ligation	☐	☐	
Bypass Surgery	☐	☐	# Vessels _____
Gall Bladder Removal	☐	☐	
Hernia Repair	☐	☐	
Artificial Valve	☐	☐	
Artificial Joint	☐	☐	
General Anesthesia (GA)	☐	☐	
Complications?	☐	☐	

Write in any surgery that you have had that may be not listed:

_____

_____

_____

_____

Have you ever been told you need antibiotics before surgery or dental treatment to protect your heart or an artificial joint? ☐ Yes ☐ No

Physician: _____

Last Visit: _____

Dentist: _____

Last Visit: _____

AUTHORIZATION & RELEASE – I certify that I have read and understand the information above to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the surgeon to release any information including diagnosis and record of any treatment or examination rendered to me or my child to Medical or Dental Offices and/or third party payers.

Signed: _____ Date: _____