

# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of last complete Medical Examination? Month \_\_\_\_\_ Year \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_

Date of your last Blood Pressure measurement? \_\_\_\_\_ Reading \_\_\_\_\_

## List any medications that you are currently taking:

Medications	Quantity	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Are you allergic to any medications or substances? \_\_\_\_\_ Yes No \_\_\_\_\_ Please check boxes below

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex Rubber
- Other \_\_\_\_\_

## Are you currently under medical treatment? \_\_\_\_\_ Yes No \_\_\_\_\_

Explain: \_\_\_\_\_

Treating Physician: \_\_\_\_\_

## For Women (optional)

Are you pregnant \_\_\_\_\_ Yes No \_\_\_\_\_

Expected Delivery Date \_\_\_\_\_

Have you had a Hysterectomy? \_\_\_\_\_ Yes No \_\_\_\_\_

## Have you had any of the following?

Heart surgery, disease, attack \_\_\_\_\_ Yes No \_\_\_\_\_

Heart murmur \_\_\_\_\_ Yes No \_\_\_\_\_

High Blood Pressure \_\_\_\_\_ Yes No \_\_\_\_\_ How is it controlled? \_\_\_\_\_

Pains in your Chest  
Or shortness of breath \_\_\_\_\_ Yes No \_\_\_\_\_

Mitral Valve prolapse (dysfunction) \_\_\_\_\_ Yes No \_\_\_\_\_

Artificial Heart Valve \_\_\_\_\_ Yes No \_\_\_\_\_

Pacemaker \_\_\_\_\_ Yes No \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_ Yes No \_\_\_\_\_ When? \_\_\_\_\_

## MEDICAL HISTORY (Continued)

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

Arthritis/Rheumatism	_____	Yes	_____	No	
Cortisone/Steroids	_____	Yes	_____	No	
Ankles ever Swell	_____	Yes	_____	No	
Anemic	_____	Yes	_____	No	
Are you subject to Fainting					
Or Dizziness	_____	Yes	_____	No	
Stroke	_____	Yes	_____	No	When? _____
Ulcers	_____	Yes	_____	No	
Diabetes	_____	Yes	_____	No	How is it controlled? _____
Thyroid Problems	_____	Yes	_____	No	
Kidney Trouble	_____	Yes	_____	No	
Hepatitis	_____	Yes	_____	No	When? _____
Liver Disease	_____	Yes	_____	No	
Yellow Jaundice	_____	Yes	_____	No	
Glaucoma	_____	Yes	_____	No	
Contact Lenses	_____	Yes	_____	No	
Artificial Joints or Hip	_____	Yes	_____	No	
Emphysema	_____	Yes	_____	No	
Tuberculosis	_____	Yes	_____	No	
Asthma, Hay fever or Allergies	_____	Yes	_____	No	
Sinus Trouble	_____	Yes	_____	No	
Tonsil or Adenoid Problems	_____	Yes	_____	No	
Tonsil or Adenoid Surgery	_____	Yes	_____	No	
Tumor or Cancer	_____	Yes	_____	No	How was it treated? _____
Major Operation	_____	Yes	_____	No	What for? _____
Significant Weight Change in the					
Last year	_____	Yes	_____	No	Loss ___ lbs. Gain ___ lbs.
Diet medically supervised	_____	Yes	_____	No	For what purpose? _____
Vitamin or mineral supplements	_____	Yes	_____	No	
Fatigue easily	_____	Yes	_____	No	
Sleep well	_____	Yes	_____	No	
Snore	_____	Yes	_____	No	
Trouble breathing when asleep	_____	Yes	_____	No	
Frequently not eat breakfast	_____	Yes	_____	No	
More than (1) Alcoholic drink/day	_____	Yes	_____	No	How much? _____
Smoke or use Tobacco	_____	Yes	_____	No	
Radiation Therapy	_____	Yes	_____	No	
Chemotherapy	_____	Yes	_____	No	

## MEDICAL HISTORY (Continued)

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Venereal Disease	_____ Yes	No _____
A.I.D.S.	_____ Yes	No _____
H.I.V. Positive	_____ Yes	No _____
Blood Transfusion	_____ Yes	No _____
Hemophilia	_____ Yes	No _____
Sickle Cell Disease	_____ Yes	No _____
Bruise Easily	_____ Yes	No _____
Nervous Disorders	_____ Yes	No _____
Neurological Disorder	_____ Yes	No _____
Epilepsy or Seizures	_____ Yes	No _____
Fainting or Dizzy Spells	_____ Yes	No _____
Nervous/Anxious	_____ Yes	No _____
Psychiatric/Psychological Care	_____ Yes	No _____

Do you sleep with more than two pillows? \_\_\_\_\_ Yes No \_\_\_\_\_

Please write in any other pertinent information that has not been covered previously.

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**AUTHORIZATION:** I hereby authorize Kathy J. Farley, D.D.S., P.A. and Associates to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information, which appears, on these medical and dental histories is correct to the best of my knowledge. I also authorize Kathy J. Farley, D.D.S., P.A. and Associates to contact my healthcare giver(s) concerning my treatment if necessary.

Patient/Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_