Medical History Adult

Patient First Name *

Patient Last Name *

Have you ever had any of the following medical conditions?

- [ ] *PreMed
- [ ] Allergies
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] ASA allergy
- [ ] Asthma
- [ ] Blood Disease
- [ ] Blood Thinners
- [ ] By-Pass Heart Sx
- [ ] Cancer
- [ ] Cipro Allergy
- [ ] Codeine Allergy
- [ ] Demerol Allergy
- [ ] Diabetes
- [ ] Dizziness
- [ ] Drug Addiction
- [ ] Epilepsy
- [ ] Erythromycin Allergy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Growths
- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Heart Ailments
- [ ] Heart Disease
- [ ] Heart failure
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Kidney Disease
- [ ] Latex Allergy
- [ ] Lithium
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Mitral Valve Prolaps
- [ ] Nervous Disorders
- [ ] On multiple meds
- [ ] Pacemaker
- [ ] Penicillin Allergy
- [ ] Pregnancy
- [ ] Pregnant: No epi
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Seizures
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sulfa Allergy
- [ ] Thyroid Disease
- [ ] Tobacco User
- [ ] Toradol Allergy
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Ultram allergy
- [ ] Venereal Disease
- [ ] Zithromax Allergy
- [ ] Zoloft

Do you have any other health problems? *

○ No ○ Yes

Are you allergic to any of the following?

- ☐ Penicillin
- ☐ Tetracycline
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Metals
- ☐ Dental Anesthetics
- ☐ Other allergies

Other allergies not listed above

Are you taking any medications at this time? *

○ No ○ Yes

Have you been admitted to a hospital in the last 2 years? *

○ No ○ Yes

Are you under care of physician? *

○ No ○ Yes

Do you use tobacco? *

○ No ○ Yes

Do you use alcoholic beverages? *

○ No ○ Yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? *

○ No ○ Yes

Have you ever taken diet drug such Fen-Phen? *

○ No ○ Yes

Women: Are you pregnant?

○ No ○ Yes

Women: Do you take birth control medications?

○ No ○ Yes

Women: Are you nursing?

○ No ○ Yes

To the best of my knowledge, all of the precedings answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

Draw your signature into the box below. *

Clear

Relationship to the patient *

Name if not the patient *

Continue

Smiles of Arlington