

MEDICAL HISTORY FORM

PATIENT NAME:	DOB:	OCCUPATION:	
REASON FOR TODAY'S VISIT:			
General Medical History: (Check all that apply)			
No contributing history	Diabetes		Hives
Antibiotics prior to dental procedure	Eczema		Kidney Stones
Anticoagulants	Hay Fever/Seasonal A		 Pacemaker/Defibrillator
Artificial Joints	Heart Disease		Stroke
Asthma	Heart Murmur		Thyroid Disorder
Bleeding Disorder	Hepatitis		Tuberculosis
Breast Cancer	High Blood Pressure	_	X-Ray Therapy
Cancer	HIV/AIDS		Cold sores/Herpes
Neuromuscular Diseases			
Past Surgeries/Hospitalizations: (If NONE, please	print NONE)		
Skin History: (Check all that apply)			
No contributing history	Malignant Melanoma	_	Squamous Cell Carcinoma
Actinic Keratosis	Other Suspicious Lesi	on _	Tanning Bed Use
Basal Cell Carcinoma	Psoriasis	-	Urticaria
Eczema	Severe Sunburns		
Family History: (Check all that apply)			
No contributing history	Glaucoma	_	Malignant Melanoma
Unknown- Adopted	High Blood Pressure	_	Obesity
Autoimmune Disorders	High Cholesterol	_	Premature Coronary Heart Diseas
Colon Cancer	Liver Disease	_	Skin Cancer
Diabetes	Lung Disease	-	Thyroid Disease
Allergies to medications and type of allergic reac	tion: (example: hives, difficulty bre	athing, swelling)	
Current Medications:			
IMMUNIZATIONS/VACCINES:			
• FLU VACCINE- Have you had	your flu vaccine? Yl	ES (If so, when?)	
			Year
PNEUMONIA VACCINE- Have	you had your flu vaccine? Y		
		Month	Year