

MEDICAL HISTORY

Patient's Name _____ Sex: M F
Last First Middle

If patient is a minor, parent or guardian's name _____

In case of emergency, who should be notified? _____

Have you ever had any of the following? (Check all boxes that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hepatitis, Jaundice or
Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Kidney Disease/Dialysis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> A.I.D.S. |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Cancer | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Allergies to Medicine/
Drugs | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Allergies to Latex/Rubber | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Respiratory Disease | | <input type="checkbox"/> Chemical Dependency |

If you have any drug allergies, please list the drugs you are allergic to: _____

Have you ever had an adverse reaction to any medication? If so, please describe: _____

Please list any medication you are taking at this time: _____

Are you under the care of a physician? Yes No For what conditions? _____

When was your blood pressure last checked? _____ Blood Pressure Reading, if known _____

Is there anything else we should know about your medical history? _____

FOR WOMEN ONLY: Are you pregnant? Yes No If yes, what month? _____

Are you nursing? Yes No Are you taking birth control pills? Yes No

The above information is accurate and complete to the best of my knowledge. I will not hold Richard D. Freiboth, D.D.S., or any member of his staff, responsible for any errors or omissions I may have made in the completion of this form.

Date _____ Signature _____