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)

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

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

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

____

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

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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? ______________________________

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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 ______________________________