PATIENT MEDICAL HISTORY

Patient Name:______________________________ Age:____ Date:______________

Home Address:______________________________ Phone:______________________

City: ____________________ Email:__________________ Soc Sec Number: ____________

What is your impression of your health? ____

When was your last physical examination? ____

PLEASE ANSWER THE FOLLOWING QUESTIONS AS ACCURATELY AS POSSIBLE

1. Are you presently, or have you been under the care of a physician during the past year? For what purpose?
____
2. Do you have any medical condition or medical problems? Please explain:
____
3. Are you taking any medication or drugs? What are they:
____
4. Are you allergic to any medicine or anything? Latex Rubber? What are they:
____
5. Have you had a reaction to local anesthetic or intravenous medications? Please explain:________________________
6. Have you had complications following medical or dental treatment? Please explain:____________________________
7. Do you have bleeding problems or blood diseases? Please explain:
____
8. Are you pregnant?____ Which Month __
9. Do you smoke or use tobacco? _______
10. Comments:____________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING CONDITIONS WHICH APPLY

__ Diet pills (fenphen)
__ Sore throat
__ Migraines
__ Ear infection
__ Jaw pain
__ Cold sores
__ Mouth Herpes
__ Thyroid disease
__ Immune disease
__ Arthritis
__ Sickle cell disease
__ Dizzy spells
__ Blood disease
__ S T D
__ Epilepsy or seizure
__ Short of breath
__ Heart disease
__ Chemotherapy
__ Drug addiction
__ Genital Herpes
__ High Blood pressure
__ Bisphosphonate Drugs (Fosamax, Boniva,etc)
__ Body implant
__ Asthma
__ Hay Fever
__ Bronchitis
_ Emphysema
__ Lung disease
__ Cancer
__ Tuberculosis
__ Hepatitis
__ Hemophilia
__ Anemia
__ Jaundice
__ Bruising
__ Stroke
__ Chest pain
__ Heart attack
__ Heart murmur
__ Heart defect
__ Pacemaker
__ Heart valve
__ Diabetes

Comments:

____

The information that I have given on this form is the most complete, up to date medical and/or dental facts that are available. If my medical condition changes in any way I will inform Dr. Khoury before further treatment.

Patient Signature:______________________________________ Date:__________________

Medical History Reviewed:
Dr. ____________________________________ Date:__________________

Followup History Reviewed:
Dr. ____________________________________ Date:__________________

Comments:

____

Vital Signs:
Pulse:_________
BP:___________
Temp:_________