

PATIENT MEDICAL HISTORY

Patient Name: _____ Age: _____ Date: _____

Home Address: _____ Phone: _____

City: _____ 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

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

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: _____