Patient Name: _____ **DOB**: _____ **Ht.**: _____ **Wt.**: _____

Reason for Visit: _____ **Date Symptoms Began**: _____

PAST MEDICAL HISTORY

	Y	N		Y	N		Y	N		Y	N
Stroke or TIA			Cataracts			Depression			Cancer		
Heart Attack			Hepatitis			Hypothyroidism			Type:		
Heart Murmur			Type:			Kidney Disease			Other Medical History:		
High Blood Pressure			Epilepsy			Kidney Stones					
DVT or Blood Clots			Parkinson's			Diabetes					
Bleeding Tendencies			Multiple Sclerosis			Emphysema					
HIV			Arthritis or DJD			Asthma					
Glaucoma			Anemia			COPD					

PAST SURGICAL HISTORY

Surgery/Hospitalization	Date	Surgery/Hospitalization	Date

Notate additional surgeries on back →

SOCIAL HISTORY

Smoker? ❒ Yes ❒ No Packs per Day: _____ Years: _____ Quit: ❒ Yes ❒ No When? _____
Alcohol use? ❒ Yes ❒ No Type(s): _____ Drinks per week: _____
Caffeine? ❒ Yes ❒ No Type(s): _____ How much per day? _____
Recreational drug use? ❒ Yes ❒ No Type(s) & reason: _____ How often? _____

LIST ALLERGIES AND REACTIONS

_____

_____

REVIEW OF SYSTEMS: **Do you <u>CURRENTLY</u> have any problems related to the following systems?**

GENIITOURINARY	Y	N	CARDIOVASCULAR	Y	N	RESPIRATORY	Y	N	NEUROLOGICAL Cont'd	Y	N
Change in stream			Chest pain/pressure			Wheezing			Memory loss		
Frequency > 8x per day			Irregular heartbeat			Frequent cough			**HEMATOLOGY**		
Blood in urine			Ankle swelling			Shortness of breath			Swollen glands		
Flank pain			**GASTROINTESTINAL**			**MUSCULOSKELETAL**			Blood clots		
Pain with urination			Abdominal pain			Back pain			**ENDOCRINE**		
Change in sex drive?			Nausea/vomiting			Muscle weakness			Tired a lot		
GENERAL			Indigestion/heartburn			Joint pain/swelling			Excessive thirst		
Weight loss			Constipation			**NEUROLOGICAL**			Too hot/cold		
Chills			Diarrhea			Numbness/tingling			**OTHER**		
Fever			**PSYCHIATRIC**			Tremors					
Night sweats			Depression			Dizziness					
			Anxiety			Seizures					

VACCINATIONS AND TESTING

Date of last pneumococcal vaccination: _____ ❒ N/A Date of last flu vaccination: _____ ❒ N/A
Date of last colonoscopy and/or sigmoidoscopy: _____ ❒ N/A
Have you EVER had a problem with anesthesia? ❒ Yes ❒ No Explain: _____
Do you require antibiotics prior to dental procedures? ❒ Yes ❒ No

FAMILY HISTORY (Parent, sibling, or child)

	Y	N	FAMILY MEMBER		Y	N	FAMILY MEMBER
Diabetes				Prostate cancer			
Kidney stones				Bladder cancer			
Heart disease				Kidney Stones			
High blood pressure				Other _____			