MEDICAL HISTORY INFORMATION

Name of Primary Physician: _____ Phone: _____

Name of Preferred Pharmacy: _____ Phone: _____

Do you have or have ever had any of the following? Please check all those that apply:

☐ Acid Reflux	☐ Diabetes, Type I or Type II	☐ Hepatitis, Type A, B or C	☐ Rheumatism
☐ Allergies/Hay Fever	☐ Epilepsy or Seizures	☐ High Blood Pressure	☐ Sickle Cell Disease
☐ Anemia	☐ Excessive Thirst/Dry Mouth	☐ HIV/AIDS	☐ Sinus Problems
☐ Angina	☐ Fainting or Dizziness	☐ Hormone Therapy	☐ Snoring
☐ Arthritis	☐ Fever Blisters/Cold Sores	☐ Kidney Problems	☐ Stroke, When?
☐ Artificial Joints*	☐ Frequent Cough	☐ Liver Disorder	☐ Surgical Shunt*
☐ Artificial Heart Valves*	☐ Glaucoma	☐ Mental Disorder, Type?	☐ Thyroid Problems
☐ Asthma	☐ Headaches/Migraines	☐ Mitral Valve Prolapse*	☐ Tuberculosis
☐ Auto Immune, Type?	☐ Heart Disorder (Congenital)*	☐ Osteoporosis	☐ Ulcers
☐ Breathing Problems	☐ Heart Infection*	☐ PreMed (Antibiotics)	☐ Venereal Disease
☐ Cancer, Type?	☐ Heart Murmur*	☐ Radiation Treatment, Year?	☐ Yellow Jaundice
☐ Chemical Dependency	☐ Heart Pacemaker*	☐ Respiratory Problems	
☐ Chemotherapy, Year?	☐ Heart Surgery*	☐ Rheumatic Fever	

* This condition may require antibiotic premedication for certain dental procedures.

→ **FOR WOMEN:** ☐ Pregnant ☐ Trying to conceive ☐ Nursing ☐ Taking oral contraceptives

YES / NO

☐ ☐ **Do you have any health problems that were not listed above or need further clarification?**
If yes, explain: _____

☐ ☐ **Other than routine/annual visits, are you currently under the care of a medical physician or specialist?**
If yes, explain: _____

☐ ☐ **Have you been admitted to the hospital or needed emergency care during the past two years?**
If yes, explain: _____

☐ ☐ **Do you have Sleep Apnea, or have you ever been evaluated for a CPAP machine?**
If yes, explain: _____

☐ ☐ **Are you taking any medications, dietary supplements, or herbal medicines?**
If yes, explain: _____

If yes, do you regularly take any of the following:

☐ Echinacea ☐ Garlic ☐ Fish Oil >33gms ☐ Ginger ☐ Ginko ☐ Kava
☐ St. John Wort ☐ Valerian ☐ Vitamin E ☐ Diet or Energy Supplements

☐ ☐ **Are you allergic to any medications or substances?**
If yes, check all that apply below:
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Iodine ☐ Metal ☐ Latex ☐ Other: _____

☐ ☐ **Do you use tobacco, vape, or use controlled substances?**
If yes, explain: _____

>Emergency Contact: _____ Phone: _____ Relation: _____

****In the event of an emergency, may we share medical information with this person? ☐ YES ☐ NO**

To the best of my knowledge, all of the preceding answers are correct. If I have changes in my health status or if my medications change, I will inform Dr. Patel and the staff at the next appointment, without fail.

X _____ _____ _____
Patient, Parent or Guardian Signature | Printed Patient Name | Date

X _____ _____
Doctor's Signature | Date