MEDICAL HISTORY *Reviewed by:*___________________________

Today's date: _______________

PATIENT____
AGE_________ **SEX**_____
Primary care physician: ____________________________________

ALLERGIES:________________ ___________________
________________ ___________________

1. Do you smoke/chew tobacco products? Yes___ No___
2. Do other members of the home smoke? Yes___ No___
3. Do you drink alcohol products? Yes___ No___
4. Are you pregnant or think you may be? Yes___ No___
6. Do you have any bleeding disorders? Yes___ No___
7. Have you ever required a blood transfusion? Yes___ No___
8. Patient's occupation (job description)________________________

PLEASE LIST ALL SURGICAL PROCEDURES AND DATES IF KNOWN:
1. ____________________________ **2.** ___________________
3. ____________________________ **4.** ___________________

LIST ALL CURRENT MEDICATIONS:
__________________ ___________________
__________________ ___________________
__________________ ___________________

PLEASE CHECK ANY ILLNESS YOU HAVE HAD (if not listed, please add)

Rheumatic fever or heart disease _____
Heart attack _____
Heart murmur _____
High blood pressure _____
Abnormal heart beat _____
Asthma _____
Emphysema _____
Obstructive lung disease _____
Tuberculosis _____
Stroke _____
Seizures _____
Diabetes _____
Ulcers _______

Cancer (type)_______
____
Thyroid Disease ____
Kidney Disease _____
Hepatitis __________

OTHER: ___________________
____
____
____

Bruise easily:___Yes ___No

<u>Who or how were you referred you to our practice:</u>

____