

MEDICAL HISTORY

NAME: _____

BIRTH DATE: _____

Physicians you see at least once a year:

(Name)	(Address)	(Specialty)

Circle below: Do you have or have you had:

Yes	No	Allergic reaction to: (Circle all that apply)			
		Latex	Penicillin	Aspirin	Local Anesthetic Other _____
Yes	No	Heart Disease			
Yes	No	Heart Attack			
Yes	No	congestive heart failure			
Yes	No	irregular heart beat			
Yes	No	angina			
Yes	No	bacteria endocarditis			
Yes	No	rheumatic fever / rheumatic heart disease			
Yes	No	mitral valve prolapse or heart murmur			
Yes	No	pacemaker / stints date: _____			
Yes	No	artificial heart valve			
Yes	No	congenital heart disease			
Yes	No	stroke			
Yes	No	high blood pressure			
Yes	No	Immune suppressive condition			
Yes	No	Radiation: date _____	Chemotherapy: date _____		
Yes	No	steroid therapy (e.g. prednisone)	rheumatoid arthritis	spleen removed	lupus HIV
Yes	No	organ transplant: (which & date) _____			
Yes	No	blood disease: leukemia	anemia	prolong bleeding	
Yes	No	artificial joints: Hip	Knee	Ankle	Shoulder
		Dates: _____			
Yes	No	diabetes			
Yes	No	epilepsy or nervous system disease			
Yes	No	hepatitis (A, B, C or D) or other liver disease			
Yes	No	thyroid disease			
Yes	No	arthritis: rheumatoid	osteo		
Yes	No	cancer	Type: _____	Date: _____	
Yes	No	kidney disease			
Yes	No	lung disease: asthma	emphysema	tuberculosis	other: _____
Yes	No	stomach or intestinal disease			
Yes	No	Women Only: Are you or could you be pregnant? _____		Are you nursing? _____	

Hospitalized or surgery in the last 2 years:

Describe: _____

What medications are you currently taking? Please list below:

Yes	No	Do you take herbal medicines or dietary supplements? Please circle:					
		Echinacea	Garlic	Ginger	Kava	Valerian	Feverfew
		Gingko	Ginseng	St. John's Wort	Vitamin E	Fish Oil	
Yes	No	Have you undergone current or past osteoporosis therapy?					
Yes	No	Have you undergone current or past therapy to reduce high blood calcium?					

Dr. Haddican's office requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. By signing below, you agree that the information given is accurate and that you will notify Dr. Haddican at subsequent appointments if there are any changes in your health.

Patient signature: _____ Date: _____