MEDICAL HISTORY FORM

Patient Name ____ Date ____________

Time frame considering for surgery: [ ] within 2 months [ ] within 6 months [ ] over a year

Date of Birth: ____/_____/________ Sex: M / F Height: ___'____" Weight: __________lbs

For the following questions, circle yes or no, whichever applies to your medical history.
Your answers are for our records only and will be considered confidential.

1. Are you in good health? Yes No

2. Has there been any change in your health in the past year? Yes No

3. My last physical exam was on ______/______ /_________ By Whom: ____

4. Are you now under the care of a physician? Yes No
   If so, for what condition(s)? ____

   ____

5. The name and address of my physician is: ____

____

6. Have you had any serious illness, significant operation or hospitalization within the past 5 years?
   Yes No
   If yes, please explain ____
   ____

7. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills?
   Yes No
   If yes, please list ____
   ____

8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves or heart murmur Yes No
   b. Rheumatic Heart Disease Yes No
   c. Heart trouble, heart attack, angina, high blood pressure, stroke,
      Arteriosclerosis or any other heart condition Yes No
      1. Chest pain upon exertion? Yes No
      2. Shortness of breath after mild exercise? Yes No
      3. Do your ankles swell? Yes No

d. Allergies	Yes	No
e. Sinus trouble	Yes	No
f. Asthma or hay fever	Yes	No
g. Fainting spells or seizures	Yes	No
h. Diabetes	Yes	No
i. Hepatitis, jaundice or liver disease	Yes	No
j. Frequent or recurring mouth sores	Yes	No
k. Thyroid problems	Yes	No
l. Respiratory problems, emphysema, bronchitis, etc.	Yes	No
m. Arthritis or painful, swollen joints including jaw joint (TMJ)	Yes	No
n. Stomach ulcer or hyperacidity	Yes	No
o. Kidney trouble	Yes	No
p. Tuberculosis	Yes	No
q. Persistent cough and/or cough that produces blood	Yes	No
r. Persistent swollen neck glands	Yes	No
s. Low blood pressure	Yes	No
t. Epilepsy or neurological disorder	Yes	No
u. Are you taking vitamins or homeopathic remedies	Yes	No
v. Cancer History	Yes	No
w. Any disease, drug or transplant operation that has depressed your immune system	Yes	No

9. Have you had abnormal bleeding?	Yes	No
a. Have you ever required a blood transfusion?	Yes	No
10. Do you have any blood disorder such as anemia?	Yes	No
11. Have you ever had treatment for a tumor or growth?	Yes	No
12. Are you allergic to or have you had a reaction to:		
a. Local anesthetics	Yes	No
b. Penicillin or antibiotics	Yes	No
c. Sulfa drugs	Yes	No
d. Barbiturates or sleeping pills	Yes	No
e. Aspirin	Yes	No
f. Iodine	Yes	No
g. Codeine or other narcotics	Yes	No
h. Latex or rubber products	Yes	No
i. Other	Yes	No

What? ____

13. Do you have any other condition or disease you think the doctor should know about? Yes No

If so, explain:____

14. Are you / do you wearing contact lenses? Yes No

15. Are you / do you wearing removable dental appliances? Yes No

16. Do you wish to talk with the doctor privately about anything? Yes No

17. Have you ever struggled with an addiction such as alcohol, drugs, or cigarettes? Yes No
If so please explain : ____

Please list any additional health related information____

____

Women Only (Please answer below)

1. Are you pregnant or trying to become pregnant? Yes No

2. Do you have problems associated with your menstrual period? Yes No

3. Are you nursing? Yes No

4. Are you on any type of birth control? Yes No
If yes, which method?____

5. You are the birth mother of how many children? 1 2 3 4 5 6 7 8

6. Have you had a C-section with any of your children? Yes No

7. Do you experience any abdomen pain? Yes No

Please sign and date that you have read and filled out 3 pages in total.

I certify that I have read and understand the above information and have filled it out completely and honestly. I acknowledge that my questions, if any, have been marked with a (*) next to the question, and about the inquiries set forth above I have met with the physician, and each has been answered to my satisfaction. I will not hold my doctor, or any member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Name: (Please Print) ____

Patient Signature: __________________________________Date:__________________

Physician signature: _______________________________Date:___________________