

Confidential Medical History

Today's Date: _____		
Name: _____		
First	Middle	Last
Address: _____		
City: _____		State _____ Zip _____
DOB ____/____/____		
Phone Numbers: Home _____		Work _____
Cell _____		

Have you ever had any of the following procedures, diseases, or medical problems?

Diabetes	Y/N	Tuberculosis	Y/N
Glaucoma	Y/N	Retina Transplants	Y/N
Cataracts	Y/N	RK/PRK/Lasik	Y/N
Eye Infections	Y/N	Multiple Sclerosis	Y/N
Any Eye Problems	Y/N	Autoimmune Disorder	Y/N
Blurred Vision	Y/N	Myasthenia Gravis	Y/N
Teary Eyes	Y/N	Headaches/Migraines	Y/N
Keloids	Y/N	Alopecia	Y/N
Recent Surgery	Y/N	Plastic Surgery	Y/N
Chemical Peels	Y/N	Laser Resurfacing	Y/N
Dermabrasion	Y/N	Cheek/Chin Implants	Y/N
Cold Sores/Blisters	Y/N	Collagen/Restylane	Y/N
Retin A	Y/N	Glycolic Acid	Y/N
Eczema	Y/N	Diabetes	Y/N
Mental Disease	Y/N	Anxiety Attacks	Y/N
Cancer	Y/N	Heart Murmurs	Y/N
Heart Attacks	Y/N	Heart Surgery	Y/N
Pacemaker	Y/N	High Blood Pressure	Y/N
Jaundice/Anemia	Y/N	Lupus	Y/N
Respiratory Problems	Y/N	Arthritis	Y/N
Shingles	Y/N	Hepatitis	Y/N
Back Pain	Y/N	Pregnant	Y/N
Chemo/Radiation	Y/N	Rheumatic Fever	Y/N
Stroke	Y/N	Artificial Valves	Y/N
Blood Transfusions	Y/N	Artificial Joints	Y/N
Hemophilia	Y/N	Neuromuscular Disease	Y/N
Fever Blisters	Y/N	Epilepsy/Seizures	Y/N
Kidney Problems	Y/N	HIV/AIDS	Y/N

Please take a moment to explain the conditions that you answered, "yes" to. *(Please include dates and the name of the physician(s) that treats/treated you.)*

Are you allergic to any of the following drugs/medications?

Benadryl	Y/N	Neosporin	Y/N	Bacitracin	Y/N
Petroleum	Y/N	Sulfa	Y/N	Vaseline	Y/N
Aloe Vera	Y/N	PABA	Y/N	Cortisone	Y/N
Aspirin	Y/N	Tylenol	Y/N	Penicillin	Y/N
Codeine	Y/N	Erythromycin	Y/N	Xylocaine	Y/N
Lidocaine	Y/N	Benzocaine	Y/N	Latex/Vinyl	Y/N
Metals	Y/N				

List any other medication(s) that you are allergic to:

What type of allergic reaction do you have with the medications that you circled "yes" to.

Are you currently taking any of the following medications?

Blood Pressure Pills	Y/N	Diabetic Pills	Y/N	Insulin	Y/N
Blood Thinning Pills	Y/N	Aspirin	Y/N	Vitamin E	Y/N
Antibiotics	Y/N	Sleeping Pills	Y/N	Tranquilizers	Y/N
Headache Pills	Y/N	Steroids	Y/N	Hormones	Y/N
Arthritis Pills	Y/N	Herbs	Y/N		

Please list any other medications, not listed above, that you are currently taking:

Are you currently under a physician's care?

YES / NO

If "yes" what is the name of the Physician? _____

What are you being treated for?

Have you had any surgeries within the last year?

YES / NO

If "yes" when and what type? _____

Are you taking Aspirin per Doctor's Orders?

YES / NO

Do you premedicate before you go to the dentist?

YES / NO

MY SIGNATURE BELOW CONSTITUTES MY ACKNOWLEDGEMENT THAT ALL OF THE ABOVE INFORMATION CONTRIBUTED BY ME IS ACCURATE. I ALSO UNDERSTAND THAT IF I AM UNDER A DOCTOR'S CARE FOR CERTAIN MEDICAL CONDITIONS, I WILL NEED THAT DOCTOR'S WRITTEN RELEASE TO HAVE THIS PROCEDURE PREFORMED.

Signature of Client: _____

Today's Date: _____

Nurse: _____

NOTES:

