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PLEASE COMPLETE THE FOLLOWING GENERAL MEDICAL HISTORY FORM

Name: ______________________ Date of Birth: __________ Referred by: ____________________

Specific problems for today's appointment ____

____

Have you consulted any other Doctors, including Surgeons, about this? ☐Yes ☐No

If yes, please list their names ____

Please mark none if no specialist -Internist: ______________________ **Cardiologist:** ______________________

Ophthalmologist: ______________________ **Radiologist/Oncologist:** ______________________

SYSTEMS REVIEW - CHECK ALL THAT APPLY REGARDING YOUR HEALTH AND ADD OTHER IMPORTANT PROBLEMS

Medications: Allergic to any medications? ☐none ☐yes list them: ______________________

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On any medication now? ☐none ☐yes list them: ______________________

On any blood thinners? ☐none ☐yes last taken: ______________________

Are you taking any Aspirin or Aspirin-like products (e.g. Aleve, Bufferin, and Motrin) ***☐no ☐yes last taken: ______***

Infections
- ☐none
- ☐HIV/AIDS
- ☐hepatitis
- ☐tuberculosis (T.B.)
- ☐other: ____________

Hematologic/lymphatic
- ☐normal
- ☐anemia
- ☐bleeding problems
- ☐enlarged lymph nodes

Constitutional Symptom
- ☐none
- ☐weight loss/weight gain
- ☐fever
- ☐other: ____________

Eyes/Ears/Nose/Throat
- ☐normal
- ☐glaucoma
- ☐hearing aid
- ☐plastic surgery: ____________

Cardiovascular
- ☐normal
- ☐angina
- ☐artificial limb
- ☐pacemaker
- ☐hypertension
- ☐mitral valve prolapse

Respiratory
- ☐normal
- ☐asthma
- ☐emphysema
- ☐COPD
- ☐other lung problems: ____________

Gastrointestinal
- ☐normal
- ☐stomach ulcer
- ☐colitis
- ☐other GI problems: ____________

Musculoskeletal
- ☐normal
- ☐arthritis
- ☐artificial joint
- ☐other: ____________

Neurological
- ☐normal
- ☐stroke
- ☐seizures
- ☐other: ________

Psychiatric
- ☐normal
- ☐depression
- ☐anxiety attacks
- ☐other: ____________

Endocrine
- ☐normal
- ☐diabetes
- ☐thyroid
- ☐other: ____________

Skin
- ☐abnormal scarring
- ☐poor healing
- ☐other skin disorders
- ☐other ____________

HISTORY: **Major illness or hospitalizations:** ☐ none List: ______________________________

____

Do you take antibiotics prior to dental or other procedures? ☐Yes ☐ no if yes, what? ____________

Family History:

Has any relative had: ☐tuberculosis ☐Cancer ☐Diabetes ☐Epilepsy ☐Heart Disease ☐Asthma ☐High Blood Pressure ☐Lung Disease ☐Kidney Disease ☐Blood/Bleeding Disorders ☐Mental Disease

Relative	Age	State of Health
Mother		
Father		
Brother(s)		
Sister(s)		
Children		

Do you - Wear: ☐ dentures ☐glasses ☐ contact lenses **Smoke**: ☐yes packs per day __ ☐no ☐former smoker

Drink alcohol: ☐no ☐social/occasional drinking only ☐ other ______________________

Alcohol or drug problems/addictions: ☐none ☐yes, describe ______________________