

MEDICAL HISTORY

Name: _____ Age: _____ Sex: Male Female

What brings you to our office?

Have you ever had any medical problems? YES NO. If yes, please describe below.

Have you ever been hospitalized? YES NO If yes, please complete the following section.

<u>YEAR</u>	<u>HOSPITAL</u>	<u>REASON FOR HOSPITALIZATION</u>	<u>OPERATION</u>	<u>PROBLEMS</u>
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PLEASE INDICATE WHETHER OR NOT YOU HAVE EXPERIENCED ANY OF THE FOLLOWING CONDITIONS:

- | Yes No | Yes No | Yes No |
|--|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Heart Problems | <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack | <input type="checkbox"/> <input type="checkbox"/> Pneumonia | <input type="checkbox"/> <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> <input type="checkbox"/> Angina | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Bronchitis | <input type="checkbox"/> <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> <input type="checkbox"/> Heart Failure | <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Wear Contact Lenses |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Seizures | <input type="checkbox"/> <input type="checkbox"/> Anemia |
| <input type="checkbox"/> <input type="checkbox"/> Heart Valve Problems | <input type="checkbox"/> <input type="checkbox"/> Paralysis | <input type="checkbox"/> <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Numbness | <input type="checkbox"/> <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Porphyria |
| <input type="checkbox"/> <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> <input type="checkbox"/> Jaundice | <input type="checkbox"/> <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> <input type="checkbox"/> Heart Infection | <input type="checkbox"/> <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> <input type="checkbox"/> Female Problems |
| <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> <input type="checkbox"/> Cardiac Arrhythmia | <input type="checkbox"/> <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> <input type="checkbox"/> Herpes |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Neuromuscular Disease | <input type="checkbox"/> <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> <input type="checkbox"/> Aneurysm | <input type="checkbox"/> <input type="checkbox"/> TMJ Problems | <input type="checkbox"/> <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> <input type="checkbox"/> Blood clots in legs or lungs | <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> <input type="checkbox"/> Problems With General Anesthesia |
| <input type="checkbox"/> <input type="checkbox"/> Tuberculosis | | <input type="checkbox"/> <input type="checkbox"/> Malignant Hyperthermia |

Are you currently taking any medicines (including aspirin & birth control pills)? YES NO If yes, please list below.

<u>MEDICINE</u>	<u>STRENGTH</u>	<u>HOW OFTEN</u>	<u>MEDICINE</u>	<u>STRENGTH</u>	<u>HOW OFTEN</u>
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Have you taken any steroid medications (example: cortisone, prednisone) **in the past two years?** YES NO

If YES, please list the medicine, strength, when and how long you took it:

Have you ever taken any diet medication (example: fen-phen) YES NO

Are you allergic to any medicines? YES NO If yes, please list the medicines below:

MEDICINE TYPE OF REACTION MEDICINE TYPE OF REACTION

Are you allergic to latex? YES NO

Do you smoke? YES NO If yes; How many packs per day?

Do you drink alcohol? YES NO If yes; How much?

Do you use any recreational drugs? (example: marijuana, cocaine) YES NO

What kind? for how long?

WOMEN: **Is there a possibility that you are pregnant?** YES NO

Are you currently breast feeding? YES NO

Have you ever been treated for mental illness? YES NO

What kind? When?

What is your vocation (job)?

PLEASE INDICATE WHETHER OR NOT YOU HAVE EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS:

- | | | |
|---|--|---|
| Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Sinus problems | <input type="checkbox"/> <input type="checkbox"/> Inability to chew well | <input type="checkbox"/> <input type="checkbox"/> Hard time breathing |
| <input type="checkbox"/> <input type="checkbox"/> A sore in your mouth that won't heal | <input type="checkbox"/> <input type="checkbox"/> Chest pain | <input type="checkbox"/> <input type="checkbox"/> Clicking in jaw joint |
| <input type="checkbox"/> <input type="checkbox"/> Cold sores | <input type="checkbox"/> <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> <input type="checkbox"/> Canker sores | <input type="checkbox"/> <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> <input type="checkbox"/> Bleed easily |
| <input type="checkbox"/> <input type="checkbox"/> Change in voice not associated with puberty | <input type="checkbox"/> <input type="checkbox"/> Need to sleep with more than one pillow, otherwise you wake up short of breath | <input type="checkbox"/> <input type="checkbox"/> Frequent nosebleeds |

PLEASE LIST ANY MEDICAL PROBLEMS PRESENT IN ANY OF YOUR BLOOD RELATIVES:

(Example: cancer, tuberculosis, asthma, heart disease, diabetes, hemophilia, problem with general anesthesia)

PLEASE LIST ANY OTHER MEDICAL CONDITIONS YOU HAVE THAT YOU FEEL DR. MONSON SHOULD BE AWARE OF

PATIENT (or parent/guardian) SIGNATURE

DATE