YDSP Medical History

Name: _____ DOB: _____ Record # _____

Drug Allergies: _____

Major Surgery

Hospitalizations: _____

Medications: _____

Family Doctor: _____ Last Physical: _____ Height: _____ Weight: _____

Insurance: Medical/Dental Medicare/Medicaid Other None

Please Circle: Have you ever had any of the following:

1. Allergies-seasonal
2. Anxiety
3. Arthritis
4. Asthma
5. Back Pain
6. Bleeding Problems
7. Blood Transfusion
8. Cancer
9. Cholesterol
10. Dental Problems
11. Depression
12. Diabetes
13. Diabetes-Family Members
14. Epilepsy-Seizures
15. Eye Problems
16. Foot Problems
17. Gastritis
18. HIV/AIDS
19. Heart Problems
20. Heart Murmur
21. Heart Valve or Pace Maker
22. Hypertension
23. Joint Replacement
24. Kidney Problems
25. Liver Problems/Hepatitis
26. Mental Disorders
27. Osteoporosis
28. Sexually Transmitted Disease
29. Sinus Problems
30. Stroke
31. Ulcers

Other (specify): _____

Social/Behavioral History

1. Alcohol Use
2. Drug Use
3. Tobacco Use
4. Tobacco Use in Past
5. Regular Exercise Program

FEMALES ONLY- Are you:

1. Pregnant? _____
2. Taking Birth Control Pills? _____
3. Currently Nursing? _____

Do you have any concerns about receiving dental/medical treatment? _____

STAFF NOTES: _____

_____

_____

IMPORTANT!

The answers I have given are true to the best of my knowledge. I am indicating my consent for routine procedures such as exam, lab work, x-rays, cleanings, local anesthesia and other treatments by signing below.

Patient or Parental Consent: _____ Date: _____

Health Care Provider: _____ Date: _____

01/01/2009