



whitmiredmd.com

5931 Stanley Ave., Suite #3
Carmichael, California 95608
Tel. 916-972-1933 Fax 916-972-8614

MEDICAL HISTORY

Family Physician _____ Specialty _____

Address _____ Phone _____

Additional Physician _____ Specialty _____

Address _____ Phone _____

Have you ever been hospitalized or had a major operation? _____

Are you on a special diet? _____

Have you or anyone in your family been advised of difficulties during anesthesia? _____

Have you ever had any excessive bleeding requiring special treatment? _____

Are you allergic to any medications or substances? Please check box below :

Aspirin Penicillin Codeine Acrylic Metal Latex Other _____

Women (Please check) Pregnant Nursing Taking contraceptives

If yes to any of the starred * conditions, please call prior to your appointment. Pre-medication might be required.

	YES	NO		YES	NO
Heart Trouble/ Disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur *	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Sickle cell dse	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/failure	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever*	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of limbs	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve*	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker*	<input type="checkbox"/>	<input type="checkbox"/>	Breathing problem	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery*	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (pollen)	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (medicines)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Alzhemiers	<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>



whitmiredmd.com

5931 Stanley Ave., Suite #3
Carmichael, California 95608
Tel. 916-972-1933 Fax 916-972-8614

Have you ever had any serious illness not mentioned above? _____
Have you ever used tobacco? How much ? _____

Are you taking any medication? Please list:

Taking _____ For _____ Taking _____ For _____
Taking _____ For _____ Taking _____ For _____
Taking _____ For _____ Taking _____ For _____
Taking _____ For _____ Taking _____ For _____

To the best of my knowledge, all of the proceeding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and the staff at the next appointment without fail.

Patient 's signature _____ Date _____
Reviewed by Doctor _____ Date _____

Significant findings

UPDATES

Has there been any changes in your health since the last appointment? _____
For what conditions? _____
Are you taking any new medications? If so, what ? _____

Patient's signature _____ Date _____
Doctor's signature _____ Date _____

Has there been any changes in your health since the last appointment? _____
For what conditions? _____
Are you taking any new medications? If so, what ? _____

Patient's signature _____ Date _____
Doctor's signature _____ Date _____

Has there been any changes in your health since the last appointment? _____
For what conditions? _____
Are you taking any new medications? If so, what ? _____

Patient's signature _____ Date _____
Doctor's signature _____ Date _____