## Patient Registration/Medical History Form

**Name**_____ **Date** _____

**Patient Signature**_____ **Date of Birth**_____

**Home Address** _____ **Home Phone**_____

_____ **Cell Phone** _____

**Employer** _____ **Social Security #** _____

**Ins Co & id#** _____ **E-Mail address**_____

**Policy holder Name and Date of Birth**_____

**Are you under medical treatment now? Y/ N**

**Do you use tobacco? Y/ N Alcohol Y/ N Marijuana Y/ N**

**Have you ever been hospitalized for any surgical procedure or serious illness? Y/ N**

**Are you taking any medications including non-prescription Medications? Y/ N**

**If yes, what medications are you taking?**

**Are you allergic to or have you had reactions to:**

**Local Anesthesia Y / N Penicillin/antibiotics Y / N**

**Sulfa Drugs Y / N Sedatives Y / N**

**Iodine Y / N Aspirin Y / N**

**Latex Y / N Other** _____

**WOMEN ONLY: Are you pregnant or think you may be Are you pregnant? Y/N Are you taking birth control? Y/N Are you nursing? Y / N**

**Y / N High/Low blood pressure**
**Y / N Heart Attack**
**Y / N Rheumatic Fever**
**Y / N Swollen Ankles**
**Y / N Fainting/Seizures**
**Y / N Asthma**
**Y / N Epilepsy/Convulsion**
**Y / N Leukemia**
**Y / N Diabetes (A1C= )**
**Y / N Kidney disease**
**Y / N AIDS or HIV**
**Y / N Stomach/ulcers**
**Y / N Blood disease**
**Y / N Chemotherapy**
**Y / N Drug Addiction**
**Y / N Scarlet Fever**

**Y / N Heart Disease**
**Y / N Cardiac Pacemaker**
**Y/ N Heart Murmur**
**Y / N Angina**
**Y / N Frequently Tired**
**Y / N Anemia**
**Y / N Cancer**
**Y / N Arthritis**
**Y / N Joint replacement/Implant**
**Y / N Hepatitis/Jaundice**
**Y / N Sexually transmitted disease**
**Y / N Alzheimer's Disease**
**Y / N Blood Transfusion**
**Y / N Cold sore/Fever Blisters**
**Y / N Shingles**
**Y / N Rheumatism**

**Y / N Chest Pains**
**Y / N Easily winded**
**Y/ N Stroke If Yes (INR= )**
**Y/ N Hay fever/allergies**
**Y /N Tuberculosis**
**Y / N Radiation Therapy**
**Y / N Recent Weight Loss**
**Y / N Liver Disease**
**Y /N Mitral Valve Prolapse**
**Y / N Respiratory Problems**
**Y / N Thyroid problems**
**Y / N Glaucoma**
**Y / N Hemophilia**
**Y / N Psychiatric Care**
**Y / N Artificial Heart Valve Y/N Pain in Jaw Joints**

**Dr. Signature:**

_____