MEDICAL HISTORY FOR ADULTS

PATIENT INFORMATION:

Name: ____ DOB: ______________

Gender: [ ] Male [ ] Female [ ] Other Height: ________ Weight: _______ (lbs)

Tel/Cell: __________________________ Email: ______________________________________

Mailing Address: ____

Name of Person Completing Form: ___________________________ Relationship to Patient: ____________

Dentist/Dental Office: ____________________________________ Phone: ______________________

Address: ____

Primary Physician: ______________________________________ Phone: ______________________

Address: ____

Specialist Physician: _____________________________________ Phone: ______________________

Address: ____

MEDICAL HISTORY:

1. Do you have allergies to any drugs, supplements or latex? [ ] YES [ ] NO

   What are you allergic to? ____

   Reactions? [ ] RASH [ ] HIVES [ ] EMERGENCY ROOM OTHER: __________________
2. Do you bleed excessively after a cut or surgery? [ ] YES [ ] NO
3. Have you had general anesthesia in the past? [ ] YES [ ] NO

   Any problems? ____
4. Has anyone in your family had problems with general anesthesia? [ ] YES [ ] NO

   What problems? ____
5. List all medications, drugs, and supplements you are now taking: ______________________

   ____

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MEDICAL HISTORY FOR ADULTS (Cont'd)

FOR WOMEN ONLY: Some anesthetic drugs may harm the fetus.

6. Are you pregnant now, or could you be? [ ] YES [ ] NO
7. Are you nursing? [ ] YES [ ] NO When was your last menstrual period? ____________________
8. Do you have, or have you ever had, any of the following conditions?

HEART DISEASES:	NO	YES	WHEN	MEDICINE/TREATMENT
Heart Murmur	_____	_____	_______________	________________________________
High Blood Pressure	_____	_____	_______________	________________________________
Irregular Heart Beat	_____	_____	_______________	________________________________
Congenital Heart Defect	_____	_____	_______________	________________________________
Other Heart Problem	_____	_____	_______________	________________________________

LUNG DISEASES:	NO	YES	WHEN	MEDICINE/TREATMENT
Wheezing/Bronchiolitis	_____	_____	_______________	________________________________
Asthma	_____	_____	_______________	________________________________
Pneumonia	_____	_____	_______________	________________________________
Obstructive Sleep Apnea	_____	_____	_______________	________________________________
Other Lung Problem	_____	_____	_______________	________________________________

OTHER CONDITIONS:	NO	YES	WHEN	MEDICINE/TREATMENT
Diabetes	_____	_____	_______________	________________________________
Kidney Disease	_____	_____	_______________	________________________________
Seasonal Allergies/Eczema	_____	_____	_______________	________________________________
GERD/Ulcer/Hernia	_____	_____	_______________	________________________________
Recurrent Ear Infection	_____	_____	_______________	________________________________
Seizure Disorder	_____	_____	_______________	________________________________
Psychiatric Condition	_____	_____	_______________	________________________________
Genetic Syndrome	_____	_____	_______________	________________________________
Learning Disability	_____	_____	_______________	________________________________
Anemia	_____	_____	_______________	________________________________

8. Please list any other medical conditions: ____

____

I certify that the above information is complete and accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information may negatively influence my treatment and treatment results. I also certify that CarePoint may communicate patient information using the contact information listed above.

Patient's/Legal Guardian Signature: ____ Date: ______________

Relationship to patient, if patient not legally able to give consent: ____________________