Michael J. Nelson, D.D.S.
Small town dentistry in a big city

PATIENT MEDICAL HISTORY

Patient's Name:	Birth Date:	Date:
Address:	City, State, ZIP	Phone:
Physician Name:	Physician Phone:	
Pharmacy:	Pharmacy Phone:	
For Office Use Only:	Medical Alerts:	B.P. H.R.
Premedicate:		

Sex: M / F

Y	N		Y	N	
❑	❑	Do you smoke or use tobacco?	❑	❑	Are you taking Birth Control Pills?
❑	❑	Do you consume alcoholic beverages?	❑	❑	Are you pregnant? If Yes, # of weeks
		How Often?	❑	❑	Are you nursing?

Please Mark Y (yes) or N (no) to all of the following:

Y	N	**Heart Conditions**
❑	❑	Angina Pectoris
❑	❑	Artificial Heart Valve
❑	❑	Congenital Heart Defect
❑	❑	Heart Attack
❑	❑	Heart Surgery
❑	❑	High Blood Pressure
❑	❑	Low Blood Pressure
❑	❑	Mitral Valve Prolapse
❑	❑	Pace Maker
❑	❑	Rheumatic Fever
❑	❑	Stroke
		Other Conditions
❑	❑	Abnormal Bleeding
❑	❑	Anemia
❑	❑	Ankle Swelling
❑	❑	Arthritis
❑	❑	Artificial Joints, Pins, Screws
❑	❑	Asthma
❑	❑	Cancer-Chemotherapy
❑	❑	Radiation Therapy
❑	❑	Depression
❑	❑	Diabetes
❑	❑	Difficulty Breathing
❑	❑	Drug Abuse
❑	❑	Emphysema
❑	❑	Epilepsy
❑	❑	Seizures
❑	❑	Fainting Spells
❑	❑	Frequent Headaches
❑	❑	Glaucoma
❑	❑	Hay Fever
❑	❑	Hemophilia
❑	❑	Hepatitis A
❑	❑	Hepatitis B
❑	❑	Hepatitis C
❑	❑	Tuberculosis
❑	❑	HIV + AIDS

Y	N	**Conditions Cont.**	Please Explain Yes Answers:
❑	❑	Kidney Problems	
❑	❑	Liver Disease	
❑	❑	Sinus Problems	
❑	❑	Thyroid Problems	
❑	❑	Ulcers	
❑	❑	Yellow Jaundice	
❑	❑	Others	

Medications

Y	N	**Allergies**	Other Allergies:
❑	❑	Codeine	
❑	❑	Dental Anesthetics	
❑	❑	Erythromycin	
❑	❑	Jewelry	
❑	❑	Latex	
❑	❑	Metals	
❑	❑	Penicillin	
❑	❑	Tetracycline	

Office Use Only

Premedicate:
1. Heart Murmer
2. Pacemaker
3. Artificial Joint, Pins, Screws
4. Rheumatic Fever

Dr. Signature: