MARK R. BAGBY, DDS

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MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____ **Blood Pressure (if known)** ____ /____

Address: _____ **City, State, Zip:** _____

Phone #: _____ **Name of Occupation**: _____ **Height:** _____ **Weight:** _____

Last Visit to your Physician:	Year:	Last Physical Exam:	Year:

What brought you to our office today?		How long has this bothered you?	

YES	NO	Question
		Are you Pregnant? If so, how many months?
		Do you take Medications?
		Do you have Allergies to Medications?

YES	NO	Question
		Taking Birth Control Pills?
		If so, list type, dosage, and reason for taking (include over-the-counter medications as well as herbal supplements) <May add a separate page if necessary>
		If so, list type of medication, reaction, and date of onset. <May add a separate page if necessary>

YES	NO	Question
		Have you had Surgeries or Hospitalizations?

Please Check "Yes" or "No" to indicate if you currently have or had any of the following and circle the condition:

YES	NO	Nature of Problem	Approx. Date of Onset	Comments
		Asthma, Hay Fever, Sinusitis, or Other Allergies		
		Allergy to Penicillin, Aspirin, Local or General Anesthetic, or other Drugs: Specify in Comments		
		Blood Pressure or Heart Problems		
		Rheumatic Fever or Heart Murmur or Mitral Valve Prolapse		
		Pacemaker or Open Heart Surgery or Heart Valve Replacement		
		Diabetes, Liver, Kidney, Thyroid, or Lung Problems		
		Ulcer or Stomach Problems		
		Hepatitis or Jaundice		
		Epilepsy or Nervous Disorders		
		Bleeding or Clotting Disorders		
		Arthritis or Hip Replacement Surgery or Prosthetic Joint Replacement		
		Communicable Disease: Tuberculosis, Herpes or Venereal		
		AIDS, A.R.C, HIV Positive		
		Do any wounds heal slowly or present complications?		
		Sleep Apnea		
		Had X-Ray Treatments or Chemotherapy for Cancer?		

YES	NO	Questions	Further Details
		Do you have other Conditions not listed above?	If yes, describe.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her/his staff responsible for any errors or omissions that I may have made in the completion of this form.

Print Name: _____ Signature: _____ Date: _____

Doctor Reviewed: Signature/Date: _____