kramer irby d.d.s.

MEDICAL HISTORY

Patient's Name:
First _____ Middle Initial_____
Last _____

Comments

1. Physician's Name _____
2. Are you under a physician's care? YES NO

Since when? _____
Why?_____

3. When was your last complete physical?_____
4. Are you taking any medications or substances? YES NO

(If yes, please list medications in comments section.) YES NO

5. Do you routinely take health related substances? YES NO
6. Are you allergic to any medications or substances? YES NO
7. Do you have any other allergies? YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics, or other medications? YES NO
9. Are you allergic to latex? YES NO
10. Are you allergic to metal? YES NO
11. Are you pregnant or suspect you may be? YES NO
12. Do you use birth control medication? YES NO
13. Do you have heart problems? YES NO
14. Do you have a pacemaker or artificial heart valve implant? YES NO
15. Have you ever had rheumatic fever? YES NO
16. Are you aware of any heart murmurs? YES NO
17. Do you have HIGH or LOW blood pressure? YES NO
18. Have you ever had a serious illness or major surgery? YES NO

(If yes, please explain in the comments section.)

19. Have you ever had a radiation treatment, chemo, treatment for tumor, growth or other condition? YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? YES NO
21. Do you have any artificial joints / prosthesis? YES NO
22. Do you have blood disorders, such as anemia or leukemia? YES NO
23. Have you ever bled excessively after being cut or injured? YES NO
24. Do you have any stomach problems? YES NO

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25. Do you have any kidney problems?	YES	NO
26. Do you have any liver problems?	YES	NO
27. Are you diabetic?	YES	NO
28. Do you have asthma?	YES	NO
29. Do you have epilepsy or seizure disorders?	YES	NO
30. Do you, or have you, had a venereal disease?	YES	NO
31. Have you tested HIV positive?	YES	NO
32. Do you have Hepatitis?	YES	NO
33. Do you, or have you, had Tuberculosis (TB)?	YES	NO
34. Do you smoke, chew, use snuff or any form of tobacco?	YES	NO
35. Have you ever used any weight loss products?	YES	NO
36. Do you have any diseases, conditions, or problems not listed?	YES	NO
(If so, please explain in the comments section.)		
37. Is there anything else we should know about your health that was not covered?	YES	NO
38. Do you want to privately speak to Dr. Irby about a problem?	YES	NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient / Guardian's Signature_____

Date _____

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