E.M.MAKHOUL, D.D.S.

MEDICAL HISTORY

(Please Print)

Patient Name _____/_____/_____
First Middle Last Height Weight in lbs.

Physician's name _____Tel#_____Date of last Exam_____

	Yes	No
1. Have you ever been hospitalized for any surgical operation or serious illness? Describe:_____	☐	☐
2. Are you under medical treatment now? For:_____	☐	☐
3. Do you smoke?	☐	☐
4. Do you chew Tobacco?	☐	☐
5. Do you drink Alcohol? if so, how much do you average?_____	☐	☐
6. Have you taken any "recreational" drugs in the past year such as Cocaine, Crack, Marijuana, LSD, etc? If so, what? _____ and when? _____	☐	☐
7. Woman Only		
a) Are you pregnant? Due Date: _____	☐	☐
b) Are you Nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

MEDICATIONS

	Yes	No
1. Have you ever taken Biphosphonates Like Fosamax, Boniva, Actonel, or? _____	☐	☐
2. Have you ever taken Fen-Phen or Redux?	☐	☐

3. List all medications you are taking & for what **(please print)**

_____

_____

_____

ALLERGIES or REACTIONS TO:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Cortisone	☐	☐	Aspirin	☐	☐	Acrylic	☐	☐	Barbiturates
☐	☐	Erythromycin	☐	☐	Codeine	☐	☐	Gluten	☐	☐	Demerol
☐	☐	Keflex	☐	☐	Ibuprofen	☐	☐	Iodine	☐	☐	Sedatives
☐	☐	Penicillin	☐	☐	Tylenol	☐	☐	Latex	☐	☐	Sleeping Pills
☐	☐	Sulfa Drugs	☐	☐	Vicodin	☐	☐	Metals	☐	☐	Valium
☐	☐	Tetracycline	☐	☐	Peppermint Oil						

☐ ☐ Other: _____

☐ ☐ Local Anesthetic (Describe)_____

_____

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

	Y	N		Y	N		Y	N		Y	N
A.D.D.	☐	☐	Cold Sores	☐	☐	Hearing Problems	☐	☐	Parathyroid Disease	☐	☐
AIDS	☐	☐	Congestive Heart Failure	☐	☐	Heart Attack	☐	☐	Parkinson's	☐	☐
Alzheimer's	☐	☐	Contact Lenses	☐	☐	Heart Mumur	☐	☐	Periodontal Surgery	☐	☐
Anaphylaxis	☐	☐	Convulsions	☐	☐	Hemophilia	☐	☐	Psychiatric Care	☐	☐
Anemia	☐	☐	Coronary Bypass	☐	☐	Hepatitis A	☐	☐	Recent Weight Loss	☐	☐
Angina	☐	☐	Coronary Insufficiency	☐	☐	Hepatitis B	☐	☐	Respiratory Disease	☐	☐
Arteriosclerosis	☐	☐	Coronary Occlusion	☐	☐	Hepatitis C	☐	☐	Renal Dialysis	☐	☐
Arthritis	☐	☐	Cortisone Treatment	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Artificial Heart Valve	☐	☐	Cough, Persistent	☐	☐	HIV Positive	☐	☐	Rheumatism	☐	☐
Artificial Joints	☐	☐	Crohn's Disease	☐	☐	Hives or Rashes	☐	☐	Scarlet Fever	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	Hyperthyroidism	☐	☐	Shingles	☐	☐
Autism	☐	☐	Diarrhea, chronic	☐	☐	Hypothyroidism	☐	☐	Sickle Cell Disease	☐	☐
Autoimmune Disease	☐	☐	Digestive Problems	☐	☐	Hypoglycemia	☐	☐	Sinus Trouble	☐	☐
Back Problems	☐	☐	Drug Addiction	☐	☐	Insomnia	☐	☐	Sjogren Syndrome	☐	☐
Bipolar Disease	☐	☐	Dry Eyes	☐	☐	Irregular Heart Beat	☐	☐	Spina Bifida	☐	☐
Bleeding Abnormally	☐	☐	Easily Winded	☐	☐	Jaw Pain	☐	☐	Snoring, Sleep Apnea	☐	☐
Bleed Easily	☐	☐	Emphysema	☐	☐	Kidney Problems	☐	☐	Special Diet	☐	☐
Blood Disease	☐	☐	Epilepsy	☐	☐	Leukemia	☐	☐	Stomach Ulcers	☐	☐
Blood Pressure-High or Low	☐	☐	Excessive Thirst	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Breathing Problems	☐	☐	Eye Degenerative Disease	☐	☐	Lung Disease	☐	☐	Swelling of Feet/Ankles	☐	☐
Bruise Easily	☐	☐	Fainting/Dizziness	☐	☐	Mitral Valve Prolapse	☐	☐	Trigeminal Neuralgia	☐	☐
Cancer	☐	☐	Fibromyalgia	☐	☐	Nervous Problems	☐	☐	Tonsillitis	☐	☐
Chemotherapy	☐	☐	Glaucoma	☐	☐	No Energy	☐	☐	Tuberculosis	☐	☐
Chest Pains	☐	☐	Gout	☐	☐	Orthodontic Treatment	☐	☐	Tumors or Growths	☐	☐
Circulatory/Heart Disease	☐	☐	Headaches, frequent	☐	☐	Pacemaker	☐	☐	Venereal Disease	☐	☐

Other: _____

COMMENTS: _____

_____

_____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health.

_____ _____
Signature of Patient, or Parent, or Guardian Date

_____
Doctor's Signature